THE

Journal of the American Medical Association.

EDITED FOR THE ASSOCIATION BY JOHN B. HAMILTON.

PUBLISHED WEEKLY.

VOL. XII. CHICAGO, JANUARY 26, 1889. No. 4.

ORIGINAL ARTICLES.

ON THE MANAGEMENT OF FEVERS IN CHILDREN.

Read in the Section on Diseases of Children, at the Thirty-ninth Annual Meeting of the American Medical Association, May, 1888.

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In inviting your attention for a few moments to some points in the management of child fevers, I am fully aware that the subject is trite—that it has been thoroughly written by far more scholarly pens, and that in a texture so well woven it would be hard indeed to cull even a few threads of purely original thought. My apology, if apology be necessary, must be found in this—that it is not the rare and infrequent diseases which most perplex the practitioner, but oftener the most common departures from health. The phenomena which constitute a coryza are certainly familiar, but the treatment of a "bad cold" is an opprobria medicorum. No less familiar to our observation is the phenomenon of fever, and no more explicit is its etiology.

The object of this paper is to provoke a profitable discussion upon the mechanism of fever, to ascertain, if possible, the object which Nature designs to accomplish by its inauguration, and to determine what means are best calculated to promote that object and hasten the return of the patient to a state of health. The vast amount of literature, and the widely diverse views of the most celebrated authors, render it apparent that still more careful study is necessary before the practitioner at the bedside can answer these questions with entire satisfaction to himself or to others. The fevers of childhood known as the eruptive fevers, or exanthemata, require no separate allusion. As a class they have been observed through so many centuries and are so well understood that they shall form no part of this paper.

The existence of nerve centres in the brain and spinal cord, whose function is to preside over calorifaction, is universally acknowledged, if not conclusively proven. These centres, when disturbed, are found to be both excitant and inhibitory. Hence fever may occur either by an increase in heat production or a prevention of its dissipation. I see no reason why nerve force may not be transformed into heat, as in the current of electricity. The introduction of morbific material, in microörganisms, and their rapid reproduction within the body as a cause of fever, is also generally accepted. Fevers originating in poisonous effluvia have been properly called "pythogenic" by Murchison. If to this class we add those which are symptomatic, the classification of child fevers would be sufficiently extensive. We can no more conceive of an idiopathic fever than we could of an idiopathic hypertrophy of the heart or any other internal organ. Suffice it, then, that in whatever manner fever may be produced the process is the same, and denotes a resistance on the part of the body toward its enemies. The character of the fever and its duration also marks the constitutional vigor of the patient. As a general rule, those belonging to the sanguino-nervous temperament are good fever patients, and those of a phlegmatic habit succumb more readily. Pain has been termed very aptly "Nature's alarm bell," and the interminable net-work of nerves of sensation has been wisely arranged for this purpose. Fever may be termed the red light of danger, and wherever this signal flashes it is a warning to go slow. The fevers of childhood are sudden in their occurrence, short in duration, and aside from involvement of internal organs or other complications, tend to recovery. By far the greater number are symptomatic in origin, and subside with the removal of the cause; such are denominated ephemera, or febricula. Fever, however produced, denotes the ability of the organism to fight the cause. There is much truth in the statement that "who caught up a fever can get well." In our search for extraneous causes we are apt to ignore the possibility of internal origin.

In my experience these constitute by far the most frequent causes of child fever. It is all very well to examine into the sanitary condition of our houses, to inspect the sewerage, the drainage, and ventilation, to be careful to sleep high and avoid dampness and marsh miasm—but there are thousands of individuals who are hypersensitive and hypocritical upon the point of house sanitation, whose bodies, the soul's dwelling, are defiled in

every possible manner. We read much of the consequences of choked drains, while we suffer the intestinal tract, the "cloaca magna" of our bodies, to be packed, and to germinate bacteria, and ptomaines more potent than marsh miasm in the production of fevers. We are hardly yet beginning to appreciate the consequences of chemical changes and fermentation within the body. The subject of ejesta is as important as that of injesta, and the bacillus subtilis in the intestinal tract may yet prove as important for our study as the bacillus typhoideus now supposed to be *the* cause of fever. Moreover, all children are not alike prone to fever. What child physician has not become familiar with fever families? and upon careful examination the children will be found those whose diet includes luxuries and dainties, thus stuffing and clogging excretory organs, and excluding necessary and healthful exercise in the open air. To my mind it is possible to have such a complete and perfect action of the various functions of the body, that not only will not cause disease to exist within, but if these causes be brought from without into the body, they will be repelled. There can be no doubt that when the skin is kept in a perfect condition the interchange of gases takes place after the manner of the lungs. Elevation of surface temperature indicates a lung action in that part. A diagnostic point upon which I place the greatest importance in infantile pneumonia is, that the elevated temperature corresponds to the affected lung.

The care of the skin, both as to prophylaxis and treatment in fever, is second to no other consideration. It is now known in physiology that while every organ has its particular function, there is no organ which may not assume the duties of others, and that vicarious action is oftentimes the salvation of our lives, by which we escape the punishment of our own neglect. The ferments designed for digestive purposes may be changed into most virulent poisons, as they are themselves excrementitious. Hence the treatment of child fevers becomes at the same time the prophylaxis, and should include the following important considerations:

1. A greater abundance of pure fresh air.
2. Anti-thermic rather than a pyretic medication.
3. Careful regulation of the diet of the patient.
4. The daily ablution of the whole body in water at a temperature agreeable to the patient.
5. A forced dilution by frequent draughts of water or other fluids.
6. Very little medicine, and such medication to be restricted to the indications of nature in diseases.

IDENTITY OF REMITTENT AND TYPHOID FEVER IN CHILDHOOD.

All authorities agree that typhoid fever is exceptional in infancy, rare in early childhood, and becomes more frequent as we approach adult years. It is possible that statistics upon infantile fever may be considerably changed, especially between the ages of five and fifteen years, by a more careful observation of cases called remittent fever. It was at one time believed that rheumatism was a rare disease in childhood, until a trained observation overthrew the traditional "growing pain" of the nursery, and threw an important light upon the occurrence of serious cardiac lesions originating in infancy and childhood. It is to be regretted that no settled conviction exists in the minds of practitioners in regard to what constitutes a remittent and a typhoid fever in the child. Under the idea that typhoid is to be excluded at an age indefinitely fixed by statisticians, we find many excellent physicians conducting a case with all the anorexia and pyrexia, the characteristic tongue, the tympanitic abdomen, the ochre stools, and the delirium of typhoid fever, through fourteen or twenty-one days of time, under the diagnosis of remittent or simple continued fever; often as entero-colitis, and still oftener as a typho-malarial attack. It is not at all unusual in such cases to find that the diagnosis also has undergone several changes, entailing a useless if not a positively dangerous variation in therapeutics. If there be no practical difference between these diseases, why preserve the nomenclature? Strike the name remittent fever from the nosology of children's diseases. I am aware that a more careful study of disease naturally results in further division, but it would seem here that increased knowledge leads to a more complete concurrence of opinion that remittent, so-called, and typhoid fever in the child are synonymous. I cannot but think that such a simplification would result in a purer practice and a lessened mortality.

W. H. Day, in his excellent work on "Diseases of Children," writing upon typhoid fever, makes use of the following language: "I must disavow at once any belief in an infantile remittent fever as caused by a separate and distinct poison, or that the disease differs in its nature or causes from typhoid. I can conceive few greater blunders in practical medicine than to consider this a separate and distinct affection, not following the same course as typhoid fever, and not leading to the same complications." Further on the same author concurs in the idea that the term remittent fever should be limited to the mildest cases, which run a short course without developing the severe typhoid. Such cases have no rash and appear to be due to a depraved condition of the alimentary canal. Dr. J. Lewis Smith admits the similarity of the two diseases but endorses the existence of a remittent fever in childhood arising from dentition, worms and gastro-intestinal inflammation. The same author describes an essential remittent fever due to malaria, to which he devotes a very

short chapter. But under the head of typhoid fever, in his excellent treatise, we find the following suggestive sentence, "It (typhoid) is probably more common under 6 years than is commonly supposed." Dr. West is clear upon the identity of typhoid and remittent fever, while Hillier advises the term remittent to be ignored. Again there is no good reason for retaining the name remittent to be applied to a mild form of typhoid. What untold evil continues to result from the idea engrafted upon the laity that scarlatina is a diminutive? Do we not recognize grades of typhoid in adult practice? Not over eighty per cent. have the characteristic eruption. What grades exist between the "walking case" and the severer forms? Most of the writings upon remittent fever are so filled up with exceptions that they are entirely valueless to the practitioner.

We are living in a period of the world's history unprecedented in brilliancy. The developments made by the microscope and by vivisection are wonderful, and have revealed a previously hidden creation. The fabric of past theories of disease has been shaken from turret to foundation stone. Synthetic reasoning is prolific in theories, but no sooner do we seize upon one than it dies in giving birth to another. Cast upon the medical world decked in the gorgeous attire which genius alone can give, they dart across our mental horizon and go out in darkness. The microbian craze has seized upon our vital pathology while poor old lame and worn out therapeutics comes hobbling along in the rear, scarcely daring to breathe and ready to apologize for being in existence at all. We have indeed been led into new pastures, but not beside still waters. So far the treatment of fever by attacking the bacillus has not proven a success. Like the Hebrew children, we take our harps down from the swaying willows and turn our thoughts again toward Jerusalem.

Considering that fever is but the evidence of the warfare which nature has inaugurated against a foreign or domestic foe I prefer to speak of the management rather than the treatment of child fevers. The maxim which I endeavor to keep before me in child practice, "Childhood is a period of life requiring the greatest amount of knowledge and the least amount of medicine." If, as I know is true, I use less quinine among children than my fellow practitioners it is because I have found it unnecessary when a careful attention has been paid to the secretions and excretions. There are certain well-known requirements in the management of a fever which accepted by all are followed by none: A large airy chamber—if possible an upper room—with free ventilation, an exposure to sunlight, an abundant supply of fresh water for bathing and drinking, a very light diet, and a kind and obedient nurse.

If, as is commonly the case in children, we are called early for the anorexia preceding the fever, or in the first week of typhoid, the following routine is ordered: an effectual evacuation of the stomach by ipecac and warm water, followed by hourly doses of $\frac{1}{10}$ gr. calomel for 24 hours; a warm soap and water bath, a regular soaker; clean linen and underwear, both on person and bed. This occupies two days of treatment, and when well done one-third of the cure has been effected. If the fever be an ephemera or febricula often the the entire cure is accomplished. If at this stage there is still a doubt as to the fever being malarial and not typhoid, I order suitable doses of muriate of quinine perfectly dissolved in muriatic acid and syrup of orange; this is administered in such doses and intervals that malarial complications may be left out and a diagnosis arrived at early. So soon as this fails to control the fever—and it becomes apparent that we are dealing with the specific cause—quinine should be stopped, nor should it again be given until convalescence may call for its tonic action. A tumbler of water containing dilute muriatic acid is placed near the patient and sipped occasionally through a bent glass tube, and the fever coil is applied to the head if restless. Food is not urged, but it is necessary not only to allow but to urge that frequent draughts of water be given, and along with this I use very small doses of morphia or opium throughout long-continued fevers, especially in typhoid. I find that small doses of opium stimulate the brain and support the nervous system far better than food, while many authorities agree that the elimination of urea is increased by it. There is no medicine in typhoid equal to small, very small, doses of Tully powder when symptoms of restlessness or delirium are present.

REDUCTION OF TEMPERATURE IN FEVER.

Fashion rules in medicine no less than in society—to be out of fashion is to be out of the world. History repeats itself, and no sooner does the great pendulum reach the utmost limit than it begins to sway slowly backward. Abandoned remedies become new, and old exploded ideas are again worshiped at our shrine. A few years ago the medicine man at the bedside of a little sufferer had but one thought, and that was temperature. Society meetings developed into a few patient listeners to long lists of hourly thermometric observations, in which all other symptoms, even the disease itself, was lost sight of. The temperature man with his lengthy tables has had his day, and we instinctively take a full breath of comfort in the belief that he will not return.

I have no doubt that very many persons have succumbed to the Don Quixotic fight waged against temperature alone. It is an extremely hard pull if the child has to contend against two forces: the specific poison of the fever and the toxic action of medicine. I hope no one will infer from these sentences that I have discarded the

fever thermometer, on the contrary, I rely implicitly upon its teachings; I use it just as an experienced seaman would use the lead, not in plain sailing but when approaching a lee shore. The minute predictions which some doctors are able to make by degrees and fractions upon a thermometer is suggestive of a story I once heard of a Nantucket sea captain who could tell his soundings and fix the exact position of his ship by the smell of the lead. One of his crew wishing to test the old man's power of discernment carried, the next voyage, some ground dug from his own garden. When, after the voyage, the ship was returning and the lead was ordered to be thrown the sailor opened the sack and rubbed the lead in it before taking it down to the cabin. "Great Heavens!" exclaimed the captain, "Nantucket has sunk and we are at this moment over old Nancy Hackett's garden."

Hydrotherapy reaches its maximum of usefulness in the fevers of childhood. The greatest possible extremes, however, have been reached in the application of cold. Such frigid packs as are recommended by authors in Ziemssen are certainly opposed to what we know of heat production and heat laws. It is not surprising that they have found so few advocates in our day. Driving the heat from the surface is no more reducing the temperature of the blood than surrounding a fire by a wall is reducing the heat within the furnace. Any application of cold which causes a continued horripilation of the skin, must necessarily produce internal congestion, and the statement made by advocates of the ice pack, that such complications as bronchitis and pneumonia would have occurred independent of such application must be taken *cum grano salis*. In children moderately ill of fever a warm bath should be given daily, preferably in the evening. In those who are too ill to be removed from the bed, the warm wet pack is to be preferred. So great is the benefit accruing from filling the cutaneous vessels and the sedative effect of moist vapor upon the nervous system that anodynes are unnecessary. The same procedure is equally beneficial in acute infectious diseases.

That dimethyloxy, quinizin, antipyrin, and acetanilide are able to reduce fever heat no longer admits of doubt. The *modus operandi* is a matter of more important consideration. It has been established by numerous experiments, that antipyrin and antifebrin inhibit the organizing power of the blood corpuscle. In this strangulation the latter is far more powerful. That this explanation is not alone able to account for the action of these wonderful drugs, is shown in the fact that other agents possessing still greater power are found to be less efficacious. I am convinced that all the compounds of phenol and salicylic acid, the chinoline derivatives, exert an anaesthetic effect over the heat centres before mentioned. It is easy to conceive how drugs which intefere with oxygenation and which cause the oxyhæmoglobin to be replaced by metahæmoglobin can become dangerous. Neither of these drugs should be used in the consolidated lung of pneumonia or pushed when there is evidence of retained carbon dioxide in the blood. In uncomplicated typhoid I regard antipyrin safer and more efficacious than gelsemium, aconite or veratrum. I know of no advance in therapeutics of more practical importance than this: that with the same agents with which we reduce temperature we allay pain and quiet reflexes without the use of narcotics.

Practically I have obtained the finest possible effect from the phenate of ammonia in the fevers of childhood. I have made very extensive use of the preparation known as M. Declat's Sirup Ammonia Phenique, both in the gastric or fermentative fevers and in the several forms of typhoid; and I can certainly substantiate the claim made by the manufacturer of nascent phenic acid to be well founded. I am satisfied that Drs. Jackson and Barnett, of Wisconsin, and M. Robins, of Paris, are correct in the statement that according to the accepted theory of heat production in fever, ammonia is the proper base for phenol and salicylic acid. I have never met with as good results from prescriptions filled at drug stores where ordinary carbolic acid is dispensed. Phenic acid requires not only great pharmaceutical skill in its manufacture, but also in its preservation in the nascent state.

ALCOHOL IN FEVERS.

The want of definite knowledge of the action of alcohol in the system is productive of very serious errors in its use in fevers. Prof. Austin Flint in his most admirable and exhaustive address before the Ninth International Medical Congress, devotes much space to the good effects of alcohol in the treatment of fevers, and places great stress upon the wonderful tolerance presented by the patient, making this tolerance the guide to the quantiy to be exhibited. His words are, "that in fever, only such quantity of alcohol as is readily oxidized is useful," also that its use is "to supply heat and save waste of tissue in fever." "It is not unusual," says the same author, "to administer from sixteen to thirty-two ounces of brandy in twenty-four hours." Bartholow says, that from one ounce to one and a-half ounces may be oxidized under twenty-four hours, the excess must be eliminated as pure alcohol and acts as alcohol upon the nerve structures and tissues. Alcohol is a food only in the most restricted sense of that term. As a stimulant it is often needed and I do not hesitate to use it under such indications. It is rapidly followed by depression, and requires as much care and judgment as the more dangerous medicines. Ger-

minal tissue is killed by alcohol, and I have never seen a child fever treated by alcohol which I thought could not have been better treated without it. The claim that alcohol in enormous quantities, saves life in snake bite, dissection wound and diphtheria is based entirely upon its stimulating properties and not upon its apyretic action as a respiratory food. All that ought to be said of it in fevers is, that when indicated as a stimulant in grave atony, its use is not contra-indicated by the high temperature present. Diluted with water and sponged upon the naked body, it is certainly beneficial in abstraction of heat, and the same effect is delightfully refreshing.

FEEDING IN FEVER.

Nothing pertaining to the treatment of fever can be of greater importance than diet. Few doctors are sufficiently explicit in their directions. It is a subject which has been characterized by the greatest possible extremes. It is possible that in olden times patients were starved to death by the doctor; and it is equally true that in the attempt to reform this treatment hundreds and thousands have died of over-feeding. The desire expressed by Graves, that his epitaph should be, "he fed fevers," is as likely to perpetuate error as truth, and the injunction, "Don't let your patients die from starvation," does not preclude the idea that they may be killed by over-feeding. Dogs may be prevented from going mad in August by killing them in July. The danger at present is entirely in the other extreme to which we have been carried by gazing upon the spectre of inanition. Nothing is more common than to find the young and inexperienced practitioner stuffing a fever patient one hour with quantities of milk and egg-nog, and the next with beef-tea and peptonoids and bovinine, and the next with medicine, until it is impossible to find an unoccupied hour for sleep. Actually the amount of food fed to fever patients under the dominant idea of preventing exhaustion, in a single day, would be sufficient to sustain the life of a well child for a week. I have seen children ill with typhoid fever suffering from retained curds of milk cheese as large as my fist at a time when danger from intestinal ulceration was imminent. Their cries from pain being attributed to tumefaction, opiates would be freely used to restrain the action of the bowels. I have never seen any good result from forced feeding in typhoid fever. It is granted that fever produces certain changes in the digestive organs rendering the assimilation as well as the digestion quite impossible. Such changes are noted in the peptic glands, pancreas and liver, while the saliva—the first essential—is wholly inadequate to do the work of ptyaline.

Upon this point Dr. Flint says: "The practical skill of the physician is taxed to the utmost in individual cases *to overcome these difficulties; but the judicious administration of milk, eggs, farinaceous articles, meat broths, meat essences, etc., is always productive of good results.*" With all due respect for the distinguished author, I *must differ*. Here, again, let us interrogate nature more closely in regard to this diminution in the digestive and assimilative function — whether or not these changes are not also conservative. It is granted that one of the principal dangers in typhoid fever is the poisoning of the system with the product of histolysis. Are we lessening this burden of the kidneys by adding to the ozonized waste? It is claimed that the hydrocarbons should be freely given to supply respiratory food and aid in the production of heat, and then alcohol is at once the most acceptable form in which to effect an entrance of hydrocarbonaceous food into the system. At the same time experiments prove alcohol to paralyze the ozonizing power of the blood corpuscles. The subject of lithæmia in fevers is certainly an important one, the study of which is calculated to greatly modify our idea of feeding. It is commonly stated that fat people have a more intense pyrexia than those who are wanting in adipose tissue, a statement which my observation in child fever has not confirmed. And if fat were an objection as supplying food for the fever, how can we reconcile this argument with the idea that we ought to feed hydrocarbons in fever?

In phthisis the blood corpuscles are cut down to suit the requirements of the lung in supply of oxygen, and any attempt to reinstate them by administration of iron while the capacity of the lung remains crippled is followed by increased irritation and injury. When in the aged the arteries become brittle by deposition of earthy material in their coats, do not we see, *pari passu*, with such change, fatty degeneration of the heart muscle? and is not this a wise provision of nature against rupture of such blood-vessels? If we were to mistake nature's object in this compensation, retrograde though it be, and administer digitalis, would we not precipitate the danger? I must confess to a more careful study into such provisions of nature the older I grow in medicine, and I heed them more.

In one accustomed to pay some respect to the appetite in fevers as a guide to feeding, I offer a limited quantity of milk, preferably buttermilk or skimmed milk, and if not willingly taken, wait. As to beef-tea, there is not a pound of nourishment in a ton of the stuff. Five grains of nitrate of ammonia in a tumbler of water discounts beef-tea.

The power of common salt in promoting cell activity and osmosis ought not to be lost sight of in long continued fever or illness of any kind attended by wasting. I always feed salt in the milk or water in sufficient quantity to secure this result and prevent indigestion of the little food allowed. With children sick with typhoid I have found

Mellin's an excellent food. I use it with milk and barley-water, and find that it is relished and digested.

QUIET.

It is estimated that life may be sustained independently of food and water for six or eight days —with water without food very much longer. If, however, muscular exertion be added, death will more rapidly ensue. Muscle glycogen is an important element, and in order to husband the forces reserved by the body for these emergencies, perfect rest must be enjoined. The wasting in typhoid is of muscular fibre, preserving the adipose tissue to a great extent uninjured. In consumption the reverse is the case, and the fats are absorbed. Sudden death from cardiac failure is the penalty of exercise or exertion, even when the patient is convalescent.

Finally, the selection of a good tonic for the convalescent stage of fever is often a matter of importance. Ordinarily the return to health after the fever poison has expended itself is rapid and permanent, and the emaciation of the body is rapidly made up to a point of plumpness exceeding that from other illness. The return of appetite indicates that nature's best tonics will be borne, and air, exercise and diet begin to demand attention. In many cases, however, the appetite is capricious after the tongue has become clean, and there are other evidences of damage from the struggle. No tonic has accomplished so much at this time as the citrate of iron and ammonia given in infusion of columba.

Previous to its discussion a vote of thanks was extended by the Section to Dr. Larrabee for his valuable and timely paper, and it was referred to the Committee on Publication with the request that it be printed in THE JOURNAL at an early date.

DR. JENKINS remarked that he was greatly interested in Dr. Larrabee's paper. There were two points upon which he wished to speak. *First*, as to the identity of infantile remittent and typhoid fevers: Twenty years' experience had led him to believe that remittent fever in the child, as in the adult, is frequently malarial. Children are more susceptible to malarial influence than adults, and often have remittent fever from a malarial influence only sufficient to cause intermittent fever in adults. He thought typhoid fever quite frequent in childhood and even in infancy, but entirely distinct in its etiology and different in its clinical history from remittent fever. Febrile movement is very readily induced in infancy from indigestible food, cold, etc., and is frequently remittent in character, but it is not of specific origin, and therefore neither malarial nor typhoid.

Second. He most heartily agreed with the paper as to the importance of restricted diet and abundance of water in the fevers of infancy and childhood. Infants with fever nurse more frequently, in consequence of thirst, and water, not food, is demanded. The stomach is overloaded and fermentation induced, invariably increasing the febrile movement, and favoring the development of eclampsia, gastric catarrh, etc. A restricted diet is of special importance during the first week of typhoid, while there is hyperæmia and infiltration of the Peyerian glands. Excessive feeding at this time increases the engorgement and causes a greater amount of necrosis. It is after the first ten to fourteen days, when the fever is partially free from the absorption of septic elements from ulcerating surfaces, that sustaining treatment by nutritious and easily digested food given at frequent intervals, together with stimulants and tonics, is of great value.

DR. JOHNSON said typhoid fever does not always follow a prescribed course and is not always of a severe nature. He uses quinine early to aid in diagnosis, and then discontinued its use. He also substituted water for milk.

DR. LAWRENCE wished to defend the young and inexperienced men in the profession from the damaging assertion that they stuff their patients with milk, beef-tea, gruel, etc., giving nature no time for that rest which she so much requires. Thinks the younger man less liable to forget his physiology and commit so great an error, than the one on whose head has fallen the snows of many winters. He then spoke of the superiority of cold as a therapeutic agent in the reduction of temperature. Did not advocate the symptomatic treatment of fevers. Uses arsenic in preference to quinine in malarial fevers of children, on account of its being well borne, of a pleasanter taste, and the certainty of its effect.

DR. BOYCE would add his testimony to the value of antipyrin in typhoid fever, also would corroborate the paper in its entirety. He too used quinine as a diagnostic agent.

DR. CHRISTOPHER said that the results of the recent investigations of the blood in malaria had proved that the diagnosis of this disease could now be made with ease and certainty by the microscope. Not so, however, in typhoid fever, since the cultivation of the bacillus of typhoid is so tedious and difficult. During the past fall and winter Cincinnati had been visited by an epidemic of typhoid which appeared first among children. He had, in this epidemic, three cases in children under 2 years of age—18, 14 and 9 months of age respectively. In all these the disease pursued a typical course of about two weeks' duration. The usual eruption was present and all had sordes on lips. The disease was modified according to the age of the child, the bronchial symptoms being more prominent, with corresponding involvement of the large intestine, so frequently seen in bronchial catarrh in young children.

EXPLORATORY LAPAROTOMY.

Read in the Section on Surgery, at the Thirty-ninth Annual Meeting of the American Medical Association, May, 1888.

BY HENRY O. MARCY, A.M., M.D., LL.D.,
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The safety of laparotomy by modern surgical methods has so greatly increased the utility of the operation, that the time has arrived when it may be advantageously discussed as a means of diagnosis. Although the clinical differentiation of abdominal disease has been much advanced in later times, it is clearly conceded by those of the widest experience that many important conditions can only be approximately determined by all the other means at our disposal.

As if in mockery of my own views, only within the week have I made two autopsies upon my own patients which serve pointedly as an illustration. The one, a sufferer from obscure abdominal symptoms, died from a sudden hemorrhage caused by the rupture of a post-uterine vascular growth, which could have been diagnosticated in no other way than by exploratory section. The second, a chronic sufferer for months from severe local pains about the pylorus, where the diagnosis of an eminent consultant, as well as myself, lay between impacted gall-stones, or cancer. Symptoms of an acute peritonitis supervened, causing death in a few days. This, viewed in the light of an autopsy of a week previous, where somewhat similar symptoms had been produced by an actively developing cancer, seemed to settle the case as malignant. To our utter surprise, the post-mortem revealed an acute apendicitis caused by a fœcal concretion which had supervened with ulcerative perforation as the cause of the acute peritonitis. A stenosis of the pylorus was found, caused by old adhesions about a degenerated gall bladder, full of concretions, but this had nothing to do with the immediate death of the patient.

We have all of us, in our years of experience, more or less often met with abundant illustration of the uncertainty and obscurity which marked the progress of the fatal issue from intestinal obstruction, tuphlo-enteritis, extra-uterine fœtation, abdominal tumors, etc., and, until recently, considered we had exhausted our skill in symptomatic treatment, where the autopsy has shown, could we have known earlier the changes taking place, surgical aid might have saved life and restored health.

The dangers attendant upon laparotomy are still considered so great, and the fear of results are so fixed in the general opinion of the profession, that it is yet looked upon as a *dernier ressort*. Most of us in middle life have watched the development of the operation almost from its inception, and some keenly remember the opposition, which assumed even a personal type, in daring to put into execution our convictions.

In the development of modern surgical methods, the experience of the profession is now sufficiently ample to warrant a revision of its teachings, and the object of this paper will be accomplished by your active participation in the discussion of the subject, to which I contribute the following report of laparotomies, which includes only and all the cases where I have opened the abdomen, and finding conditions which did not warrant further operative measures, closed without surgical interference.

Case 1.—Female, æt. 30. Opened abdomen in 1880. Interstitial myoma. Five years since it first gave the patient trouble. Filled pelvic basin. On account of the vascular supply, deemed it unwise to remove ovaries or growth. Recovery easy and rapid. Patient living and far more comfortable since.

Case 2.—June, 1885. Child, æt. 4 years. Seen in consultation with Dr. Adams of Framingham, and aided him in operation two days later. Case supposed malignant, acute. Temperature 105°, pulse 150. Suffering severe, abdomen distended with fluid looking like pus, odorless, creamy, which, on examination, was shown to be a pure development of micrococci (after cultured to several generations). Operation determined upon because of character of fluid. Abdominal cavity carefully washed out with a weak mercuric bichloride solution. Perfect recovery followed. Patient living and growing finely.

Case 3.—May, 1886. F., æt. 60. Slow development of an enormous abdominal distention. Uterine myoma filled the pelvis, but diagnosis uncertain. Fifty pounds of fluid removed. Recovered from operation and was greatly relieved, but died a few weeks later.

Case 4.—Nov., 1886. Male. Subject to frequent attacks of illness, with great pain in region of appendix. Temperature reaching to 104°. Localized soreness and tenderness. Appendix not involved, but bands of adhesion at head of cœcum were divided. Recovery complete, followed by a gain in weight of over thirty pounds. Remains well.

Case 5.—Nov., 1886. F., æt. 30. Under observation in hospital for some months. Severe pain and emaciation. Uterus fixed. Perhaps a case of old tubal disease. Laparotomy showed disseminated tubercle mesenteric and over the abdominal walls. Resected a small portion for examination. Washed out with mercuric bichloride solution and closed the abdomen. The miliary masses proved to be colonies of tubercular bacilli, and cultivations were made which reproduced true. Recovery followed, with an improvement of all symptoms. Patient sailed for Europe the following spring, and in a letter under date of August, 1887, she writes, "Am enjoying at present very good health, being able to work again."

Case 6.—February, 1887. Female, æt. 28.

Patient confined to bed with severe abdominal pains. Tumor on right side, reaching nearly to umbilicus, accompanied with many of the symptoms of pregnancy. Uterus evidently merged in the growth. Proved an ectopic pregnancy. Closed the wound. Miscarriage followed. Recovery complete and patient remains well.

Case 7.—April, 1887. F., æt. 30. Patient ill four weeks. Tumor on right side, growing rapidly. Exploration revealed cancer of omentum. Closed wound. Autopsy later showed round cell sarcoma. Thought result not materially changed by operation.

Case 8.—April, 1887. F., æt. 33. Pulse and temperature high, with severe pains caused by a tumor of right side extending to umbilicus. Although from subsequent history probably cystic, it was found everywhere adherent and judged malignant. Patient still living, but for the most part confined to the bed for the year. Tumor increasing in size, and again I have advised exploration with the hope of removal.

Case 9.—July, 1887. Dr. W., æt. 72. Sufferer for years from gall stones. Now *in extremis* from biliary obstruction. Laparotomy and found adhesions to ascending colon and the parts about. Could feel and probably dislodged, in a measure, a calculus, size of a walnut. It was thought not safe to proceed further, so closed the abdomen and improvement followed for a short period. Wound healed perfectly. Symptoms of obstruction returned and death supervened within a month. Autopsy showed a large impacted calculus and conditions which warranted the conclusion that the duct adhesions prevented a safe removal.

Case 10.—August, 1887. Boy, æt. 12. Perityphilitis. Freely separated adhesions. Patient recovered well from operation. Wound healed. Death about six weeks later from undetermined cause. Autopsy showed the intestine unobstructed, and only delicate bands to determine place of the extraordinary plastic effusion.

Case 11.—October, 1887. Child, æt. 2. Temperature 104° and pulse 140 to 150. Opened and washed out a large pus cavity involving appendix, drained. Improvement most marked from time of operation. Some weeks later enlarged the incision on account of return of fever, etc. Closed a fistula of the bladder by a continuous tendon suture and two openings in the large intestine which admitted finger, also the abdominal wall. Recovery complete and rapid. Child growing finely, and seems as strong as before her long illness.

From this report it will be seen, although the list of cases is small, that life was not seriously endangered by the operations, and in more than one instance, although seemingly only exploratory, the recovery was dependent upon the surgical interference. To write the opposite side of my experience would be to narrate a long series reaching over more than twenty years of active clinical study, where the post-mortem revelations have taught the shortcomings of our art, and with regretful sadness caused us, at least, the contemplation of what might have been.

I am well aware that I am not alone in the consideration of exploratory laparotomy as to the views taken of the subject in this brief paper. Prominent among the contributions upon this subject, I take pleasure in citing an able article recently written by Dr. T. Gaillard Thomas, of New York City. In the light of the criticisms of a certain considerable and highly respectable class of the profession, raising the protest against what they deem an unjustifiable resort to laparotomy for abdominal disease, I can but believe that it emanates, as a rule, from men only theoretically interested in the subject. Of the quite large number of surgeons, in Europe as well as America, with whom I am personally acquainted, I know of no men more conservative in opinion, or who review with greater care and precision the premises upon which they base the advisability of operative interference, and only a long experience and extended observation has led them to accept exploratory laparotomy as, at times, the only means of a correct diagnosis.

Let us hope those younger in the profession who have entered upon its labors under more favorable auspices, will take heed to such warning, profit by the lesson it teaches, and remember that the future, if not the present, will regard the sins of omission in the same stern light as those of commission.

HYDRIODIC ACID. ITS USES IN GENERAL PRACTICE.

Read in the Section on Practical Medicine at the Thirty-ninth Annual Meeting of the American Medical Association, Cincinnati, May, 1888.

BY WM. C. WILE, A.M., M.D.,

EX-VICE-PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION; MEMBER OF THE BRITISH MEDICAL ASSOCIATION; EDITOR OF THE NEW ENGLAND MEDICAL MONTHLY, ETC.

The difficulties which were in the way of the use of hydriodic acid because of its rapid decomposition, were considered so unsurmountable, that it was not until the year 1878, when an unalterable syrup was presented to the profession, that it came into use. Soon after this, in 1880, my attention was attracted to an article by Dr. J. B. Oliver, of Boston, which was published in the *Boston Medical and Surgical Journal*, of the issue of March 4th of that year.

Dr. Oliver, in his paper alluded to the use of syrup of hydriodic acid, in the treatment of asthma, and in conclusion says, that Dr. Knight "had surprisingly satisfactory results," from the same remedy. Having under observation at this time a severe case of chronic asthma, complicated with chronic bronchitis, on which I had

tried iodide of potassium, which was intolerable to the stomach, I at once put the lady, a woman of 49 years, upon the syrup of hydriodic acid. The effect was all that could be desired. There was an almost immediate relief from the asthmatic conditions, rapid amelioration of the cough, decreased expectoration, which was very profuse before the exhibition of the remedy. The sputa which was thick and viscid, became thinner in character, and my patient's general health commenced to improve, and after three months of the use of the syrup of hydriodic acid, in increasing doses till two teaspoonfuls were taken three times a day, complete recovery took place, and from that time till her death of pneumonia two years later, had no relapse. The results in this case were so satisfactory, that ever since it has been my favorite remedy, *in all* asthmatic troubles, and though every case has yielded promptly and effectually as this one, still, I have never administered it in this class of diseases, without unmistakable evidences of relief and comfort. In chronic bronchitis of long standing, in my hands it has produced most excellent results, and can be given when the iodide of potassium cannot for a moment be tolerated. The cases which seem to derive the most benefit from this remedy, are that class of long standing bronchitis, when the lung seems about to take on a deeper seated and less tractable form of disease.

My attention has been frequently called, in the treatment of chronic bronchitis with hydriodic acid, to the fact that small doses, frequently repeated are of signal service, when larger doses do not seem to accomplish the same results. In fact, from long experience, I would suggest the constant use of the syrup in small doses, 15 drops, gradually increased a drop a dose, until the point of toleration is reached, in order to get the most satisfactory and lasting results. While practicing at Sandy Hook, Conn., I had the opportunity of observing its action in lead poisoning, in a great many cases, lead entering largely into the compounds which are mixed with the crude rubber during the process of manufacture. I depended almost entirely on the syrup of hydriodic acid for all forms of chronic lead poisoning. In lead paralysis, this remedy combined with keeping the bowels quite free, and the application of the Faradic current were the only means employed, and always with satisfactory and oftentimes surprising results. Wrist-drop and chronic abdominal pains would yield to the remedy, combined with saline cathartics. In scrofulous diseases, of children especially, does the hydriodic acid seem to produce most marvelous results. In infantile eczema, enlarged glands, cold abscesses, indolent sores, treated with small doses gradually increased until it is all that can be borne, will prove a source of great gratification to the patient, and gratitude towards the doctor.

At the suggestion of my friend, Dr. F. A. Burrall, of New York, I am using it in a case of obesity, with the result of steady diminution of the amount of fat, without a single disagreeable symptom, or interference with the general health, or the action of any of the functions of the body. In hay fever it has been used by other observers with good results, but my own experience with its use in this disease has been *nil*.

It is hardly necessary for me to more than say, that in all the latest stages and manifestations of syphilis, it has yielded its most magnificent results. Pleasant to take, rapidly pushed to large doses, I have found the most pronounced and favorable effects. Patients take it readily, and the improvement is so rapid and immediate, that they need no urging to continue its use for as long a time as the doctor deems desirable.

My paper has now reached the limits which I prescribed for it, but I cannot resist the temptation of recording briefly three of the most unique cases of my experience with this drug. The one was a man 42 years of age, who was a paper-box manufacturer, suffering from arsenical poisoning from the inhalation of arsenical dust arising from the glazed paper which he handled and cut. After repeated trials of other remedies, the syrup of hydriodic acid made a complete cure inside of a month.

In Danbury, the city in which I now reside, they make large quantities of hats; in fact, it is said that at least one-half of the hats made in the United States, are made in that place. To preserve the fur, "carrot" is used, which is composed largely of mercury; consequently, many of the hatters working in the plank-shop suffer from mercurial poisoning, and many from mercurial tremor and paralysis. No remedy has proved of so much value to me as the hydriodic acid. Always prompt in its effects and reliable in its results. The last case was one of chronic rheumatism in a man 37 years old. He was almost a complete cripple in his hands and feet, and had not done a stroke of work in two years. I had exhibited every remedy known to me, including electricity, massage, Turkish baths, colchicum, etc., but until I commenced the use of the hydriodic acid, no permanent improvement was made. After continuing its use for four months the patient seemed, and was to all appearences entirely well. For fear of relapse, he continued taking it for two months more, in order as he explained it, "to make assurance doubly sure." I do not believe that this remedy is enough understood, or the advantages it possesses over all other forms of iodide as thoroughly appreciated as it should be; but of this I am assured, that it will be tolerated by the stomach many times, when no other preparation of its class can be retained, and do work that none other will. It is scarcely necessary for me to

state, that I have never used any other preparation than that of the originator of the unalterable syrup, of Mr. R. W. Gardner, of New York.

THORACOPAGUS.

Read before the Medical Society of the District of Columbia, June 13, 1888.

BY D. S. LAMB, M.D.,
OF WASHINGTON, D. C.

I present, herewith, a double monster, known as a *Thoracopagus*. It was procured by Dr. E. C. C. Winter, who placed it in my hands for a few days. The mother was a young negro, and this was her first pregnancy. She stated that so far as she knew, there had been no deformity nor even twins in the family history of her husband or herself.

There is but one umbilical cord; for which reason the monster has been also called *omphalopagus*. There are two distinct heads and necks, and as is usually the case, one is smaller than the other. Indeed some writers affirm that one of a double monster is *always* the smaller. The bodies, otherwise than the heads of this specimen, do not show any marked difference in size. On one side the limbs are separate and perfect, on the other the arms coalesce, though from a superficial examination, I conclude that two sets of bones are present; the hands are separate; on the same side the lower limbs also are united like the arms, while the toes are separate, except that the great toes are fused. The trunks are joined a little to one side of the middle line, though no doubt the actual bony junction is by the sternum; whence the monster gets its name *sternopagus* or *thoracopagus*.

Dissection not having been permitted as yet, we can only infer the arrangement of internal organs from what is usually found in these cases. The heart is probably double; the alimentary canal is very likely in part common to both segments; the liver doubtless double, but the two organs joined by process of gland substance. The position of the anal openings is represented by two teat like prominences in the normal situation; while the genitals appear as two similar prominences in juxtaposition, and behind each of them a small opening. Doubtless females.

The size of the monster would indicate an age of about five months.

Although this specimen is the commonest kind of double monster, yet the shelves of the Army Medical Museum show but one specimen of this kind.

There are other specimens in which the fusion has also included the head; others in which it has included the face; others in which the head only is involved. Out of over twenty specimens, only two are human; a *thoracopagus* and a *prosopothoracopagus*; one of these was contributed by the Medical Faculty of Columbian College of this city, in 1867.

There are besides, however, a number of specimens in which one of the two segments of the double monster is much smaller than the other, so that it appears parasitic. There is an *acardiacus acephalus*, which was presented before this Society some years ago by Dr. Harrison Crook of this city. It may be called a placental parasite, because the parasitic segment which is without head or heart, and hence the name it bears, was connected to the same placenta as the antosite or host and depended upon the latter for its circulation. There is also a specimen of *thoracopagus parasiticus* from the human subject, a cast from the Warren Museum of Harvard University; and represents an infant which lived to the age of five months and had a parasitic infant, devoid of head and neck, and with only part of the trunk, the heart being absent, joined to the thorax of the host.

There is a specimen of *cephalo-thoracopagus parasiticus*, that is to say, fusion of both heads and thoraces. This was contributed by the Medical Faculty of Columbian College of this city in 1867. There is also a *teratoma* from the late Dr. Joshua A. Ritchie of this city. There are also specimens in which the duplicity is either anterior or posterior only. Altogether the collection is fairly representative with desiderata, however, especially in the matter of the human subject.

I put this matter in this shape to emphasize the desirability of making the collection, already valuable, even more so, by rendering it more complete; and for this purpose to enlist the interest of the members of this Society. I would add that all of the information I have given in regard to these museum specimens can be verified by any inquirer from the labels attached thereto.

The most interesting question, perhaps to all of us, is that of causation. What is the preponderating opinion now among investigators as to the cause of these monsters? I will try briefly to present the matter to you.

In the first place, since a monster may be single or double, it might be inferred, and truly, that the cause of the one was different from that of the other. Single monsters show arrest of development, or an absence of one or more parts. It is therefore called a monster by defect. Sometimes, however, there is instead, a deviation in structure or position of a part, as shown in transposition of the viscera of the thorax and abdomen. On the other hand, double monsters show us a fusion of two nearly similar individuals; or one of them may be poorly developed and therefore parasitic; or lastly, particular parts may be doubled or simply hypertrophied.

The cause must be one of two, unless it be both; namely, either inherent and inherited in the

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ovum, or external. The probability seems to be that the influence of heredity in malformations is small; and chiefly limited to cases of slight importance, as hare-lip, cervical fistula, and excess of fingers and toes. Ziegler says: "The pathological peculiarities transmitted congenitally from parent to child manifest themselves less in anomalies of external form than in deficient or perverted function of the tissues, or in morbid predispositions. Such anomalies are to be detected only by minute anatomical examination, or they are incapable of anatomical demonstration at all."

In single monsters the cause may be usually set down as being either from disease or injury of the uterus or of the fœtus; or possibly, at times, both. As to the uterus, there may be defective development or disease of the membranes; adhesion of the amnion to the fœtus; abnormally small quantity of amniotic liquor; tumors of uterus; concussion of the uterus with separation of membranes; or hemorrhage into the membranes or their vicinity. As to the fœtus, there may be inflammation transmitted from the mother; there may be inherited diseases, as syphilis; or there may be in the early stages of development, abnormal flexures.

These causes act either mechanically by simple pressure; or they hinder the circulation of the fœtus; or directly destroy the parts involved, as in inflammation. More than one cause may act at the same time. The effect is usually as stated, arrest of development.

A very interesting point is the period of embryonic life at which the cause acts. The earlier the injury, the greater the effect; the loss of a few cells at an early period may involve the loss of a limb, but at a later period, may have no appreciable effect. Since the general form of the body is defined by the end of the third month, malformations, strictly speaking, should originate within that time.

We study double monsters from a different point of view. We go back to the blastodermic vesicle and find there two embryonic areas instead of one. In the segmentation of each of these areas, neighboring cells of the two may mingle to a greater or less extent and a double monster be produced. Or in place of two separate rudiments, we may have a cleavage of one mass of cells; complete or partial cleavage; the two masses thus formed may partially reunite, the result being the same as fusion of two separate rudiments. It seems to me that the weight of opinion is with the doctrine of cleavage. Two primitive streaks may appear in the same embryonic area, and subsequently two medullary grooves; these may remain distinct or may become partly blended. We may also suppose a primitive streak to remain single while the medullary grove is duplicated. In any case we assure a duplication of parts which are ordinarily single.

The cause of such cleavage is unknown. Marchand adduces observations on invertebrates which makes it probable that that the admission of two spermatozoa to one ovum may lead to the formation of two centres of segmentation. Gerlach tried to produce double monsters by varnishing eggs before incubation, leaving uncovered only a Y shaped space over the region of the primitive streak, and succeeded in obtaining one case of anterior duplicity.

I might add that malformations have been produced by varying the temperature of the incubator; by raising the temperature too far above the normal; by varnishing the eggs; by placing them vertically; by prolonging the interval between the laying and incubation of the eggs.

Since we observe the same kind of malformations in the lower vertebrates as in the human subject, it follows that, the laws must be the same, and what is demonstrated in the former must inferentially hold good in the latter.

In conclusion I desire to suggest what has doubtless occurred to many others. It is this: The ancients constructed a mythology and, as the modern idolators, made images of cyclopian, and many headed, many breasted and many limbed figures. I do not think that they drew entirely on their imagination for these figures. I would rather think that they have copied from those single and double monsters which they must have repeatedly had before them from the various parts of the animal kingdom. The ignorant mind has a peculiar dread of such monsters and is even to-day disposed either to deify or demonize them.

A PATHOLOGICAL CHANGE AT THE BASE OF THE TONGUE, POSSIBLY EXPLAINING CERTAIN SO-CALLED FUNCTIONAL DISEASES OF THAT ORGAN.

Read before the Medical Society of the District of Columbia, October 10, 1888.

BY C. W. RICHARDSON, M.D.,
OF WASHINGTON, D. C.

During the last decade the advance in laryngology has been so great that the number of cases of nervous origin, or functional, has been so vastly reduced that the so-called nervous and hysterical cases are becoming rather limited in their number. It has only been within this period that attention has been called to several important pathological lesions situated at the base of the tongue giving rise to symptoms which seemed never to be relieved by the methods of treatment previously in vogue but now completely cured, enabling us to relegate a large number of so-called nervous cases to their proper sphere. It is in hope, by calling attention to some further changes in this organ,

of still further reducing the number of nervous cases that I present the following paper. We recognize, most thoroughly, that there are a certain number of cases presenting no pathological changes, due seemingly to perversity, that may forever belong to this sphere, but that there are still a large number that will be withdrawn from this field of uncertainty no one doubts.

On July 1, a lady was referred to me by Dr. H. D. Fry, who in a note stated that the lady supposed a fish bone to be lodged in her throat and she claimed the same having remained there since —a period of six weeks. She made the same statement to me and added that shortly after she made attempts to remove the object with her finger, but was unsuccessful. The bone continued to give her considerable annoyance, especially during the intervals between meals, causing her to make frequent efforts at "empty swallowings." While she could always feel the presence of the body yet its position was never such as to cause any interference with the act of deglutition, nor to any apparent obstructive sensations. She states that the swallowing of bread-crust would diminish, momentarily, the intensity of her sensations, which was no doubt due to the roughness of the bread "scratching" the mucous membrane. The supposed location, she states, was somewhat lower at first than at present. The location of the sensation frequently changed, at one time being on the right, again on the left side and then in the middle of the throat.

Such a history as the above, with regard to the change of location in the position of the bone, seemed quite unusual for that of a foreign body —such bodies, especially if pointed, usually remain fixed in the position they originally take, The pharynx and larynx I examined with the utmost care, although little expecting, on account of symptoms given, to find any trace of the supposed origin of the trouble. My examination not being attended with success, and as the patient was unusually tolerant, I determined to make a digital examination of her throat. This was also unsuccessful. I subjected her to three subsequent examinations, all of which were attended with the same result. The only deviation from the normal noticed in the throat, which arrested my attention during the first examination, was a peculiar vascular condition of the right base of the tongue. This condition I did not at first attach as much importance to as upon subsequent examinations and more mature consideration. A similar condition, attended with exactly an analogous train of symptoms, not arising from an analogous cause, we have since noted in another patient. The pathological change which I refer to is the existence of a small area of ecchymosis or submucous hemorrhage grouped together like a bunch of grapes. This area of hemorrhage effusion, or "spots" as I shall designate them, had the appearance as though small red shot had been deposited beneath the mucous membrane. The area of effusion varied from one to one and a half centimeters in length and from one-half to three-fourths in breadth; while the individual spots varied from one-half to one millimeter in diameter. These spots while not being hard yet cause sufficient elevation of the mucous membrane to make them distinctly discernible to the sense of touch. As I have stated above, I noticed this condition during my first examination but almost immediately dismissed it from mind as I thought it probably due to the irritation caused by the presence of the foreign body. During my second examination these spots aroused my suspicion and I determined to touch them lightly with the probe. On touching the spots and requesting the patient to state whether I was near the point at which she located the sensation, she intimated that I had touched the exact point. She then informed me that she was now certain that I would be able to remove the object inasmuch as I had been so successful in going directly to the point where it was located. After three days she reported again, her face radiant, and greeting me with unusual cordiality, she stated that she had certainly felt the bone with unusual distinctness within the last hour. It had changed its position from right to left. On introducing my mirror I was somewhat surprised to find the same pathological condition manifested on the left side that I had previously noted, three days before, on the right. A few days later I noted a similar condition near the centre of the base of the tongue, and with this new focus an alteration of the supposed site of the bone to this new point. On each subsequent examination we noticed that the previously existing spots had diminished somewhat in area as well as distinctness. The effused blood gradually became absorbed.

On July 22 a lady whose daughter had previously been under my treatment, presented herself for the purpose of having her throat examined. Her train of symptoms were as follows: She had for several months, at varying intervals, a sensation in her throat as though something was lodged there which she must remove. This something felt scratchy, as she expressed it, very much as though there was a small area of roughness in her throat. She had had these same peculiar sensations some eight months before, but they had subsided after several weeks' duration. On different occasions she located the sensation in different positions—at one time to the right, again to the left, a little higher and then lower. She never suffered pain nor was there any obstruction of the throat or difficult deglutition. She had previously been under treatment. A spray had been placed in her hand which she was diligently using upon a normal nasal and pharyngeal mucous surface. On making a larynxal examination I was very much

surprised by the great resemblance which this case bore to the preceding one; the whole mucous surface of the larynx, pharynx and naso-pharynx, excepting that portion covering the base of the tongue, had a normal appearance. The base of the tongue presented the same pathological change, the hemorrhagic effusion, which I had noted in the preceding case. Although my experience in the preceding case would have justified my concluding that there was a certain causal relationship existing between the pathological changes present and the symptoms manifested, I was not hasty in drawing a conclusion but rather waited for further developments.

Five days later, after an almost complete subsidence of all symptoms, as well as a diminution in size and prominence of the spots, many of the smaller ones having completely disappeared, she had an increase in the intensity of her symptoms, and on making an examination a new area of hemorrhage was visible, larger and more prominent, situated three-fourths of a centimeter to the right of the former area. I introduced a probe, and in order to avoid any possible error, told the patient to indicate when I had touched the point at which she located her abnormal sensations. When the probe came in contact with the first effusion she stated that there she felt an unpleasant sensation, but not until I passed gently over the surface of the new effusion did she give any evidence of certainty as to location. I now could hardly resist the conclusion that there was, in this case, a direct causal relationship existing between the pathological changes present and the symptoms manifested. In these two cases we have symptoms almost analogous, their origin ascribed to different causes, presenting pathological changes which are identical in their character. The important question is to decide what relationship exists, if any, as regards cause and effect between the only pathological change present and the peculiar train of symptoms manifested. It is important to decide whether the symptoms existing, necessarily nervous, gave rise to the pathological changes, or whether the pathological changes having been produced were the cause of the train of symptoms manifested. Supposing the phenomena to be of a nervous character, is it possible that the patient by repeated and frequent efforts at clearing of the throat, rasping and coughing—in the effort to remove the supposed foreign body—is capable of producing a hemorrhagic effusion in this position. Admitting the hemorrhage to be produced in the manner mentioned above—no pathological change being present—is it possible for the seat of the supposed foreign body to change from that at which it was formerly located to the seat of the effusion. The hemorrhagic effusion gradually undergoing absorption, with a subsidence of the symptoms, a re-occurrence of the effusion in a somewhat removed position being attended by a re-occurrence of symptoms in their original intensity—supposing no pathological change primarily to have been present—is it possible with the full disappearance of the effusion that the symptoms will also completely subside. In other words, is it possible for a purely nervous phenomenon to attach itself to a demonstrable pathological lesion, subside with the disappearance of the lesion, recur with its re-occurrence, and to disappear entirely with the disappearance of the lesion.

The first and most important interrogation to answer, is the one in regard to the possibility of the patient, mechanically, producing the pathological lesion mentioned. During the effort of clearing the throat as well as retching the tongue is entirely a passive organ, not sufficient muscular force being used to rupture a weakened arteriole even in a state of congestion; nor do I consider sufficient congestion of the vessels of this organ to be produced, during these efforts, to produce a rupture of the capillaries at its base. We have never before noticed an analogous condition in any throat, and if seen by others they have never attached sufficient importance to it to give it a description. It is quite possible that the condition may be the same as that known as miliary aneurisms of the tongue. Butlin states: "Ecchymosis may occur in or beneath the mucous membrane from other causes than purpura;" he goes not farther, and does not mention the nature of other causes. In the cases here mentioned the patients were known not to have made any violent efforts, of the kind mentioned, and after coming under my care no efforts of this character were made, yet the effusion re-occurred several times in both cases. The burden of proof rests on the other side.

Admitting the possibility of the second supposition, which could be manifested possibly in certain phases of hysteria and melancholia—a laryngitis often causing the syphilophobiac to suppose that the chancre has re-appeared in his throat—we must admit that our patients were hysterical or melancholic. Our patients were robust women of a decidedly phlegmatic temperament, displaying no nervous phenomena of any character. They were of 50 and 45 years of age.

Even admitting the patients to be of a hysterical temperament, and the original phenomena to be hysterical, followed by the hemorrhagic effusion—mechanical in its origin—is it possible that the symptoms should disappear with the complete disappearance of the only pathological lesion manifested. I could hardly conceive of such a condition; therefore am rather forced to the conclusion that the hemorrhagic effusion was the original pathological lesion which gave rise to the subsequent symptoms.

In one case, that of the fish bone, the probable

irritant was a bone which may or may not have found lodgment in the throat. The foreign body, if it ever entered the throat, must have been immediately expelled by the effort of coughing, excited by its presence. I am rather inclined to believe that no such object ever found lodgment in the patient's throat; the effusion occurred about the same time, and she supposed the symptoms produced thereby to be the result of the fish bone. We know how unreliable the statements of patients are in regard to such matters. Patients very frequently persist in asserting that a foreign body is still lodged in the throat, weeks after the occurrence, when its lodgment was only momentary. In all cases where foreign bodies lie imbedded in the substance of the tongue it gives unmistakable evidences of its presence. *The wound does not heal* and it lies in the midst of an indolent tumor, the wound leading down to its surface. I think we must conclude that the fish bone never was present in this case; the eating of fish and the effusion occurring simultaneously, the patient immediately ascribes the phenomena produced by the effusion, to the lodgment of a bone. We can readily conceive how such would be the case, as a hemorrhage would be almost as sudden in its production—the train of symptoms as suddenly produced—as those produced by the swallowing of a bone.

In our second case we have a much simpler condition of affairs, and one in which there is not the same doubt as to the origin of symptoms. Here our patient came to me with a feeling of fulness in her throat, and the sensation of a foreign body lodged there—resembling very much the sensation imparted by a crumb of dry toast. These symptoms being greater at one time than another, and varying in their location. It seems to me that my position, at least in these two cases, is proven beyond doubt. We have here a pathological lesion, producing a train of symptoms which ameliorate and disappear with a diminution of and disappearance of the change; the symptoms to re-occur in their full intensity in another locality, with the reappearance of pathological changes in another position, the symptoms to completely subside with the disappearance of the lesion. The symptoms are somewhat analogous to those produced by enlargement of the glands at the base of the tongue, and to those arising from a varicose condition of the vessel in the same locality.

I can offer no suggestion as to the etiology or pathology of this condition.

1106 L Street, Washington, D. C.

THE next meeting of the Association will be held at Newport, Rhode Island, June, 25, 1889.

SUPPLEMENTARY REPORT OF THE USE OF SALOL IN TYPHOID FEVER.[1]

BY R. H. DAY, M.D.,
OF BATON ROUGE, LA.

In the last days of September, 1888, I was called to see a patient suffering from typhoid fever, and I was led by some recent studies of the composition and therapeutic effects of salol to give it a trial in the case before me. I did so, and with such prompt and decided success, that I deemed it my professional duty to report my experience at once to the medical profession. To this end I wrote up a report of the case for the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, and in the latter part of October forwarded it to the Editor, requesting its early publication. The Editor kindly accepted the article, and wrote me it would be printed as soon as it could be done in justice to other contributors.

Unfortunately, perhaps, the publication of my article was long postponed, owing to the many excellent papers on THE JOURNAL'S file ahead of mine; yet this delay enables me to contribute this supplementary report of a case similar in character to the first, and occurring in the same individual.

Willie Thomas, col., æt. 17, whom I discharged cured on the 3d of October, 1888, after going about for about four weeks in apparent good health, except being weak, was again stricken down on the 30th of November.

On the 3d of December I was again requested to see him. I found him lying on his back, his skin hot and dry, tongue coated dark brown, fissured and without the slightest moisture; front teeth, gums and lips coated with sordes; intellect dull and mind wandering, with muttering incoherency when dozing and frequently when awake; thin, dark, offensive stools four or five times in the twenty-four hours; urine scanty with considerable sediment, upon standing, of a pinkish and brick-dust color; abdomen more retracted than otherwise, with a sense of soreness upon gentle pressure over the whole abdominal region; no relish for food since his second attack. His pulse was very small, weak and up to 130 per minute, temperature 103.4°.

It was now just two calendar months since I discharged him cured of typhoid fever, and I recognized now the same disease and, having had such good results from salol in his previous sickness, I determined at once to give it another trial. Accordingly I prescribed 5 grs. of salol every three hours, and no other medicine to be given, that I might test salol upon its own therapeutic merits. I also directed the liberal use of port wine, Ducro's elixir, and cow's milk with beef broth.

Two days subsequently I visited my patient and took with me my friend, Dr. J. W. Dupree,

[1] See p. 80 for original report.

to whom I had narrated his previous sickness and the success I had experienced in treating him with salol. Upon seeing the patient Dr. Dupree unhesitatingly pronounced the case typhoid fever and thought him dangerously ill, though I thought I could perceive some amelioration since my previous visit.

I continued the salol and kept up the nourishment, telling the mother if he ceased to improve or she should observe any symptoms of his growing worse, to let me know immediately. Suffice it to say that I saw my patient every few days for the next ten days, and each time with marked improvement, after which I discontinued my visits, leaving him convalescent and needing only good food to establish his returning good health.

This is the second case of typical typhoid fever in which I have given salol with eminent success; in this last case, not so prompt as in the first, which perhaps is easily explained by reason of the general impairment of his physical system by his previous sickness; but even in this last case I could discern in forty-eight hours the commencement of a salutary work. And in this last case salol alone was used, and to it, and to no other drug, belongs whatever good results were accomplished.

Now, in what manner salol acts upon the human organization to exercise such a curative power in typhoid fever, it is too recent before medical observers and workers, and its trials too few, to lay down any reliable theory.

But with my limited experience of its use, I would by no means restrict its application to the treatment of typhoid fever, for since I have commenced its use, I have repeatedly given it in the diarrhœas and dysenteries of infants and children with the best results, and in the first week of January of this year, in an adult white male, Mr. E. T., attacked with *ileitis*, having frequent and copious bloody watery stools, fever and great pain, prostration and soreness over the bowels, I used salol 5 gr. with pulv. ext. opii ½ gr. every two to four hours, with prompt relief, and an established convalescence in forty-eight hours.

Judging, then, from my short but sharp experience, it appears to be suitable and useful in inflammations of the mucous coat, glands and follicles of the intestinal tract, upon which it appears to exert a prompt and peculiar beneficial influence.

Further observation and trial, and rigid scientific research must be instituted, before the merits of this new claimant to the confidence of the medical profession can be fully established and its true therapeutic value and range of application can be definitely settled, and be made of practical value to the medical profession.

Since the foregoing thoughts were written, I have read in the January number (1889) of *Gaillard's Medical Journal*, a most valuable paper by Dr. W. A. Cauldwell, of Chicago, on the "Rational Selection of the Salts of Salicylic Acid for Therapeusis," taken from the *American Medical Digest*. I find in this paper many valuable suggestions relating to the rational use of salol in medicine, and that very favorable reports are made of its administration in diarrhœa by Dr. O. I. Osborne; and that Dr. James Barnsfather reports good results of its use in typhoid fever.

RETRO-PHARYNGEAL ABSCESS AND "HEN-CLUCK" STERTOR.

BY KENT K. WHEELOCK, M.D.,
OF FT. WAYNE, IND.

My apology for offering this oft-repeated tale to your readers is found in the fact that the basis of all true knowledge lies in observation and experience, and the further fact that the general practitioner, overworked, worried with waiting and watching the eventuation of a certain case, allows his mind to drift into a groove from which it is sometimes suddenly jerked by the rough jolt of death. And the further fact that the thinking mind, delicate as a galvanometer, takes cognizance of all externals calculated to make an impression upon it.

On March 16 I was asked by the father of the child, the history of whose case I am about to relate, to meet my friend Dr. F. Greenwell, of Huntertown. I found a male child 11 months old, pale but well nourished, with a slight swelling on right side of upper part of neck in front of the sterno-cleido-mastoid muscle. A similar swelling had developed at the same region on the left side, which had eventuated in an ordinary abscess, and was opened by the doctor. Before the termination of the abscess on the left side the swelling on the right side made its appearance, and it was opened and discharged pus. After the last abscess was opened the child seemed to do fairly well till about two weeks previous to my visit, when croupy symptoms developed, coming on in the night, for which the doctor sent some temporary therapeutic agent which would serve till such time as he could see the child in person. The croupy symptoms grew worse and led to the belief that an abscess was forming in the nares so as to obstruct nasal respiration. When I saw the patient he was quite lively and able to nurse, yet continued effort at the nipple caused dyspnœa, to relieve which the child would let go the nipple and throw its head back. No pain attended swallowing, as he took large quantities of milk and water eagerly, the only remarkable feature attending such efforts being the rapidity with which he swallowed the fluid, showing that he was compelled to suspend respiration through the nose while the mouth was closed. After taking the fluids the child seemed exhausted and dropped off to sleep, at first breathing regularly enough with

stertor now and then. Soon the respiration grew more feeble and finally apparently ceased. He laid in this condition a few seconds and then suddenly awakened with an effort to catch his breath. At other times, generally between the stertor above spoken of and the apparent suspension of respiration, a peculiar clucking noise is heard, such as is made by the hen calling her brood together. It was this peculiar cry which led me to suggest that the trouble was, as I then said, "tracheal." I examined the nasal cavities carefully and found no evidence of obstruction beyond the swelling attending an ordinary cold, and passed a small bougie through the nostril to satisfy myself that there was no great swelling obstructing the nasal respiratory lumen. In examining the fauces by reflected light the mucous membrane of the pharynx had a normal pink tint. But the struggles of the child were such as to render the examination unsatisfactory without complete etherization. He was then completely subdued, and the result of the examination showed a plain right lateral bulging. Exploration with the finger rather confirmed the impression. Yet it would have been impossible to hinge a diagnosis upon tactile impressions alone. I made an incision ½ inch to right of the mesial line and a little above the margin of the soft palate, into the most dependent part of the swelling. The child was carried rapidly forward on its face, when fully one-half teacupful of pus and blood passed out upon the floor. That night the child slept without any difficulty and was decidedly relieved. On the next day I again saw the little patient with the attending physician, when all the symptoms causing the previous alarm had disappeared. The child vomited after etherization, throwing up some more pus and blood. The swelling on the right side of the neck had disappeared and the skin was thrown into delicate folds such as are seen when there has been a circumscribed swelling with subsequent relief of pressure. The child is scrofulous, and at this time the father had suffered from a series of abscesses, amongst which was one of the middle ear. Fleming seems to have been the first to give a detailed report of retro-pharyngeal abscess, in the *Dublin Medical Journal* for February, 1850, and Henoch says that he owes the diagnosis of his first case to having read this report only a few days before. The symptoms, as set forth in Henoch's "Lectures on Diseases of Children," do not differ except as to detail from what was observed in my patient. The essential feature "is a snoring sound, especially during sleep." I have not seen this peculiar cry referred to by any author as resembling the cluck of a hen, but it struck me as being so eminently similar that I believe retro-pharyngeal abscess with pressure about the glottis may be predicated upon the "hen-cluck stertor" being heard. The post-mortem in West's first case is here appended: "On dividing the cervical fascia on the right side a thick yellow, healthy pus poured out. This matter had burrowed close to the œsophagus, to within a little more than an inch of the clavicle, and also in an oblique direction behind the œsophagus toward the left side, completely detaching it from its communication on the right side, though not on the left. It passed up behind the œsophagus and pharynx quite to the base of the skull, a few shreds of cellular tissue bathed in pus being all that remained of their attachments. The tonsils were not enlarged and the glottis was neither red nor swollen."

MEDICAL PROGRESS.

YELLOW FEVER GERM. — A dispatch from Columbus, O., in the *Baltimore Sun*, says: "Professor H. J. Detmers, of the Ohio State University, has concluded the task of photographing the yellow fever germs that had been sent him by Dr. James E. Reeves, of Chattanooga, Tenn. The professor says this is the first time that yellow fever germs have been found in the tissue, scientists heretofore searching for them in vain. They have been found in zoogloœa masses in the capillary blood-vessels, which appear distended and ruptured, and at these ruptures these zoogloœa masses are dense and large. The bacilli present themselves in four forms; the first in a plain, dark, round mass; the second an oval, with a dark point at each extremity; the third, an oblong disc with dark points, as in the second, and fourth two darks united by a film, and strikingly resembling a dumb-bell. Being asked as to how the discovery regarding the cause of the yellow fever came to be made, he said: 'Dr. Sternberg, of Johns Hopkins University, for a number of years has made exhaustive searches for the yellow fever germs, but without success, in the tissues. During the last epidemic he made several post-mortem examinations at Decatur, Ala. Liver and kidney tissue of two persons at least were sent by him to Dr. Reeves for the purpose of mounting for microscopical purposes. I have several negatives, each of which is good. Some show the bacteria singly, others in masses with the capillaries distended with them.'

"Dr. George M. Sternberg is a surgeon in the United States army, and is doing his laboratory work in Baltimore at the Johns Hopkins University. He has been engaged during the past two years in investigating yellow fever under orders from the President of the United States, and in compliance with an Act of Congress making an appropriation for this purpose. Last year he visited Brazil and Mexico in the prosecution of his investigations. He also went to Havana, and in the autumn to Decatur, Ala., for the same purpose.

"He says that the announcement that Dr. Reeves has discovered the specific germ of yellow fever is entirely premature. Dr. Reeves has found bacilli in the tissues of one or more cases of yellow fever which occurred during the recent epidemic in Decatur, but bacilli had previously been seen in yellow fever tissues by Dr. Sternberg and others. Last spring in Havana Dr. Sternberg obtained by cultivation from the liver in two cases and from the kidneys in four cases bacilli resembling those which have been found by Dr. Reeves and probably identical with them. A detailed report with reference to the various microörganisms which he has encountered in the tissues and in the alimentary canal of yellow fever patients will in due time be submitted by him to the President of the United States. In the meantime he calls attention to the fact that the finding of bacilli in the tissues of one or more cases of an infectious disease is a long way from making the scientific demonstration that these are the specific cause of the disease."

THE KNEE-JERK IN DIPHTHERIA.—In a note on the knee-jerk in diphtheria DR. W. B. HADDEN, in the *Lancet*, says that so long as this remains absent the patient cannot be considered free from the risks of paralysis and of cardiac failure.

BEER COMPARED WITH OTHER ALCOHOLICS.—For some years a decided inclination has been apparent all over the country to give up the use of whisky and other strong alcohols, using as a substitute beer and other compounds. This is evidently founded on the idea that beer is not harmful, and contains a large amount of nutriment; also that bitters may have some medical quality which will neutralize the alcohol which it conceals, etc. These theories are without confirmation in the observation of physicians. The use of beer is found to produce a species of degeneration of all the organs. Profound and deceptive fatty deposits, diminished circulation, conditions of congestion, and perversion of functional activities, local inflammations of both liver and kidneys are constantly present. Intellectually a stupor amounting almost to paralysis arrests the reason, changing all the higher faculties into a mere animalism, sensual, selfish, sluggish, varied only with paroxysms of anger that are senseless and brutal. In appearance, the beer-drinker may be the picture of health; but in reality he is most incapable of resisting disease. A slight injury, a severe cold, or a shock to the body or mind, will commonly provoke acute disease, ending fatally. Compared with inebriates who use different kinds of alcohol, he is more incurable, and more generally diseased. The constant use of beer every day gives the system no recuperation, but steadily lowers the vital forces. It is our observation that beer-drinking in this country produces the very lowest kind of inebriety, closely allied to criminal insanity. The most dangerous class of ruffians in our large cities are beer-drinkers.

Recourse to beer as a substitute for other forms of alcohol merely increase the danger and fatality. —*Scientific American.*

LEUCOPLASIA AND CANCROID OF THE VULVO-VAGINAL MUCOUS MEMBRANE.—BESC.—*El Progreso Ginecologico y Pediatra*, July 25, 1888. The following are the author's conclusions:

1. Leucoplasia, which has been described heretofore, as it appears in the buccal mucous membrane, appears also in the vulvo-vaginal mucous membrane.

2. It is an affection which is characterized by white patches, and its lesions consist in a thickening of the epithelial coat and the corium.

3. Like buccal leucoplasia, the form which involves the vulvo-vaginal mucous membrane may be the first step in the evolution of papilloma and cancroid.

4. Leucoplasia and cancroid are distinct affections: the first plays the part of an irritant and prepares the soil for the evolution of a second,

5. In regard to treatment:

a. The leucoplasia patches must be treated in the beginning with hygienic and medicinal means.

b. If the patches are rebellious to treatment, and are circumscribed, they should be extirpated.

c. If papillomata have developed, they should be removed as thoroughly as possible, the section extending well beyond the limits of the diseased tissue.—*Annals of Gynecology.*

THE TOXICOLOGY OF COCAINE.—M. MUSSI, in *Annales de la Société Medico-Chirurgicale de Liége* has applied his investigation to the problem of how much of the alkaloid could be recovered in cases of poisoning by cocaine.

He experimented on rabbits which had been subjected to the subcutaneous injection of fatal doses of cocaine. To isolate to alkaloid he employed the proceeding of Stas-Otto, slightly modified.

He was not able, 48 hours after death, to find cocaine in the vitreous humor, the brain, the liver or the kidneys. The heart, the blood and the lungs furnished traces. Four days after death, the alkaloid had completely disappeared from all the organs.

The author concluded by expressing the opinion that in fatal cases of cocaine poisoning it will not be necessary for the most expert chemist to attempt a quantative research, for in the majority of cases it will furnish no indication of the dose absorbed.

THE
Journal of the American Medical Association.
PUBLISHED WEEKLY.

SUBSCRIPTION PRICE, INCLUDING POSTAGE.
PER ANNUM, IN ADVANCE.....$5.00
SINGLE COPIES.....10 CENTS.

Subscription may begin at any time. The safest mode of remittance is by bank check or postal money order, drawn to the order of THE JOURNAL. When neither is accessible, remittances may be made at the risk of the publishers, by forwarding in REGISTERED letters.

Address
JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION,
No. 68 WABASH AVE.,
CHICAGO, ILLINOIS.

All members of the Association should send their Annual *Dues* to the *Treasurer*, Richard J. Dunglison, M.D., Lock Box 1274, Philadelphia, Pa.

LONDON OFFICE, 57 AND 59 LUDGATE HILL.

SATURDAY, JANUARY 26, 1889.

REPORT OF THE SURGEON-GENERAL OF THE ARMY.

SURGEON-GENERAL MOORE has just made public his annual report. In all financial matters the report covers the operations of the fiscal year ended June 30, 1888, from the appropriation made by the Act approved February 9, 1887, for the expenses of the Medical Department of the Army. The money value of the medical and hospital supplies issued during the fiscal year was $178,034.11, and the Surgeon-General estimates that the cost will exceed that amount for the current year. In regard to the employment of "contract surgeons" and the Hot Springs Hospital, the Surgeon-General says:

"The limited number of contract surgeons allowed by law necessitates the employment of private physicians, under existing regulations, to furnish medical attendance to officers and enlisted men at stations where there is no medical officer of the Army. These physicians are paid by the visit from the 'medical and hospital appropriation.' Added to this is the necessary expenditure for the employment of skilled nurses for the proper care and treatment of cases of epidemic and contagious diseases.

"The merging of the appropriation for the maintenance of the Army and Navy Hospital, Hot Springs, Ark., into the appropriation for the Medical and Hospital Department by the Act, approved September 22, 1888, adds to the amount to be expended for the pay of employés, the pay-roll of said hospital, which has been at the rate of $12,000 per year. The amount fixed by said Act for pay of employés is $42,000, which in my judgment will not be sufficient to meet the necessities of the service for payment of employés at the medical purveying depots, medical directors' offices, and the U. S. Army Dispensary, Washington, D. C., heretofore allowed by law at $36,000, and paid from the appropriation for the Medical and Hospital Department—and, in addition thereto, the employés of the Hot Springs Hospital. The limit should therefore in my opinion be not less than $48,000.

"The order of the President, prescribing the regulations for the administration and government of the Army and Navy Hospital, Hot Springs, Ark., provides that the employés of said hospital shall be *civilians*."

The bulk of the report is on the "Health of the Army," which covers a different period of time from that given in the financial statement, as it is made for the calendar year which ended December 31, 1887. The report states that

"To facilitate the study of the influences exerted upon the health of troops by peculiarities of environment, the territory of the United States, over the whole of which the Army is dispersed in numerous small commands, has been divided into regions, each of which is characterized by distinct physical features and climatic conditions, and the various items of information embodied in this report have been arranged as far as possible in accordance with that division. Following the statistics relative to the health of the troops serving in the different regions, the subject of the health of the whole Army receives consideration, and the principal facts in connection therewith are given.

"The regions into which the country has been divided for the purposes of this report are eleven in number, as follows: The Atlantic Coast, Eastern Timbered Plains and Hills, Appalachian, Northern Lakes, Central Timbered Plains and Hills, Alluvial, Gulf Coast, Prairies, Great Plains, Cordilleras, and Pacific Coast. Some of these regions, on account of their great extent north and south, have been subdivided into groups of military posts."

For those of mathematical turn of mind the succeeding fifty pages may be of thrilling interest, but it is of real importance to those concerned in maintaining the health of the Army. The remaining pages are of general interest to the profession.

"The number of cases treated in hospital during the year was 14,403, in quarters 14,800, and in the field 524, giving admission rates of 621, 604 and 22, per 1,000 of mean strength of the whole Army, respectively. For 1886 these rates were 546, 688 and 29.

"Counting admissions to sick report of every description, the average loss of time on account of sickness during the year was 15.5 days for each man in the Army, showing a change for the worse as compared with the previous year, the average for 1887 being 1.1 days higher than that for 1886, and only .6 of a day lower than that for the previous decade. The average for the colored troops was 16.8 days, and for the white 15.3.

"The ratios of constant non-effectiveness, per 1000 of mean strength, of the various armies are as follows, arranged in the order of their relative positions: Great Britain (1885), 57.9; *United States* (1887), 42.38; *United States* (1876–1885), 44.0; Austria (1886), 41.0; France (1884), 39.3; Prussia and Würtemberg (1881–1882), 38.9; Italy (1885), 33.4; Belgium (1886), 28.8.

"The ratio of non-effectiveness due to diseases was 33.70, per 1000 of mean strength (white 33.47, colored 35.84); that due to injuries was 8.68 (white 8.52, colored 10.23).

"The constant non-effective rate of patients treated in hospital was 28.37, in quarters 13.62, and in the field .39, per 1000 of mean strength of the whole Army, against 25.93, 12.69, and .79 for the previous year. The fact that the admission rate of patients treated in quarters was higher than that of patients treated in hospital, while the non-effective rate of the former was less than one-half that of the latter, goes to show not only that the disabilities treated in quarters were relatively much less important factors in the impairment of the efficiency of the Army, than those treated in hospital, but that, as previously stated, the total admission rate can not be safely used for purposes of comparison, or be considered a reliable index of the health of the Army."

Concerning the Hygiene of the Army, the Surgeon-General says:

"The sanitary reports received from medical officers during the year ending December 31, 1887, bear evidence that the important duty of supervising the hygiene of the commands to which these officers were attached was performed by them, as a rule, with a full appreciation of the great responsibility devolving upon them, and with a commendable degree of intelligence and discretion.

"In the majority of instances the post surgeons received the cordial support and coöperation of their immediate commanders in the sanitary measures recommended, and, so far as the means at hand would permit, those measures were generally carried out.

"But, notwithstanding the vigilance of medical officers and the active efforts of commanding officers, the fact remains that the sanitary conditions which prevail throughout the Army are in many respects susceptible of great improvement. Some of these conditions are, beyond a doubt, already operative in the impairment of the health and efficiency of the Army, while others may become so to a most disastrous extent under contingencies which are by no means improbable or remote. The offensive and dangerous privy vault and cesspool are still in common use; lack of proper bathing facilities continues to be a constant cause of complaint; overcrowding of quarters and insufficient ventilation are frequently reported; the water-supply of certain stations is inadequate, and at others there is reason to fear its pollution; the drainage of many posts is defective; the uniform clothing is found to be altogether unsuited to the requirements of the men in hot climates;[1] and the issue of salt pork as a part of the ration is generally condemned at Southern stations, as is the deficiency in the food supply at some of them, which compels enlisted men to contribute to the purchase of fresh vegetables out of their own limited means, while at the same time the proceeds of the sale of a portion of the ration are devoted to the maintenance of a regimental band, and to other purposes entirely foreign to that of feeding the soldier.

"To remedy these evils drastic measures are required; antiquated methods must be abandoned; traditions of the service must be disregarded, and individual opinions and preferences must be overruled, where any of these conflict with the teachings of modern sanitary science. But little can be accomplished in this direction without vigorous and decisive action on the part of the higher military authorities. Such action is urgently demanded, and, in order that it may be followed by the best results, it should be taken in accordance with a plan so carefully considered and comprehensive that not only will the removal of existing evils be provided for, but their avoidance in the future will be insured."

The work of the Record and Pension Division, as stated on page 137 of the report, is a gratifying evidence of the ability and efficiency of the officers in charge of that Division, and exhibits a marked improvement on former reports. The application of the card index system to hospital registers, first recommended, we believe, by Dr. Ainsworth, is one of those labor-saving appliances that makes one wonder why it had not been thought of before. The museum now has a total number of specimens of 26,695, of which 833 were received during the past year. There were presented to the library 269 books and 5,212 pamphlets during the year, and this great medical library now has a collection of 130,614 medical books, bound medical journals, theses and pamphlets.

In regard to medical officers, the Surgeon-General states there are no vacancies at present. The deaths for the year include those of Surgeon Spencer, and Assistant Surgeons Dickson, Cunningham, King and Azpell. There are 8 medical officers awaiting retirement, and 15 on sick leave, and the service is seriously embarrassed in consequence. General Moore recommends an increase in the corps of twenty Assistant Surgeons. It is a little remarkable that the medical officers of the Army are discriminated against in the matter of retirement. Whenever a vacancy occurs on the retired list of the Army, that vacancy is said to be invariably filled by the retirement of a line officer. This is, however, not stated in the report, but is a matter of comment in medical circles at the Capital. Taking the medical corps of the Army as a whole, they have much less ground of complaint than any of the other branches of the public medical service, and it is pleasant to see on record such gratifying evidence of the efficiency and general ability of the corps.

[1] Since the close of the calendar year 1887, for which this report is made, the Quartermaster's Department has prepared and issued to the troops in the Department of Texas, and in a portion of the Department of the Missouri, clothing especially intended for wear in hot climates, which, it is hoped, will remove the cause of complaint against the uniform referred to above and in subsequent pages of this report.

ON DISTINCTIVE DRESS FOR PHYSICIANS.

"De noche todos los gatos son pardos."—*Nuñez.*

An interesting young college-graduate, whom we may call CELSUS, junior, recently made a proposition, taken up seriously in some quarters, that all physicians should wear some distinctive dress or badge, whereby a gentleman would be known to be a physician at all times, and in all circumstances.

The ostensible object of such distinctive dress, was so that in case of accident, poor suffering humanity might more speedily be relieved. It strikes us that this proposed return to mediæval cruelty would cause as much suffering as it would remove. Think of the sufferings of the young physician going to opera with his inamorata, if forcibly seized at the doorway of the theatre by a policeman and *nolens volens* dragged away to set a broken leg, or attend an immigrant child suddenly seized

with a fit. But as an advertisement it would a long way excel the happy device of Bob Sawyer, late Knockemoff, who always managed to be sent for just before the sermon commenced, but sufficiently long after the opening exercises, to insure the full notice of the congregation. It is within the memory of many, when no general practitioner in England or on the Continent went without his tall hat, his ruffled shirt, broad shoe buckles and gold-headed cane, and it was only in the last century when one must wear the silk full hosiery, the smalls, the lace sleeves, the variegated waist-coat, the peruke, and the flowing ribbons, such as Mr. Joseph Jefferson permits us to see when in "The Rivals" he personates Bob Acres. But, our young friend will say, "there is no need to act silly, nor because a man is faultlessly dressed, need he be a fop."

This might lead us to inquire what is faultless attire? Surely not the ribbons, spangles, and curled wig of the Bob Acre's family, for as Humphrey Clinker said these were "ridiculous modes, invented by ignorance, and adopted by folly"—what Swift once called a "volcano of silk, with lava buttons."

The fact seems to have been, that the old picturesque costumes were abandoned, as Farquhar said, because "here's such a plague every morning, with buckling shoes, gartering, combing and powdering," that the burden of dressing became insupportable, and fashions were adopted, which, if neither beautiful nor æsthetic, are at least comfortable, and easy of adaptation.

We very much fear that whether CELSUS, junior shall advocate a return to the old costumes, or the creation of new, he will be doomed to disappointment. Even the wearing of a distinctive button will scarcely be agreed to, as when liberty has once been granted it is not easy to put on the yoke, and one derisive joker has already rather unfeelingly suggested that the design for the button should have a pill tile for the escutcheon, bear a hypodermic needle rampant, and an unpaid bill *gules* as a bar sinister.

THE ACTIVE PERIOD OF INFECTION IN SCARLET FEVER.—The period of activity of infection in scarlet fever is discussed by Dr. Arthur Whitelegge in the *Lancet*, and he alleges that there is a sudden decrease in the infectivity about the sixth day, which is restored about the twelfth.

EDITORIAL NOTES.

PHILADELPHIA'S DEATH-RATE.—The vital statistics of Philadelphia for 1888 furnishes a text for the *Medical Register*, which calls attention to the fact that the health of the city has improved, even in the face of a bad sanitary condition. This is accounted for in the exodus of the middle and lower classes to the suburbs which has taken place in the past few years. The death-rate from consumption shows a marked decrease since 1884.

THE PENALTIES OF EVOLUTION.—In answering negatively the proposition, "Are quadrupeds subject to the hæmorrhoidal disease" Dr. William Bodenhamer remarks, in the *New York Medical Journal:* "If it is true that the erect position of man is the only predisposing cause why he is subject to hæmorrhoids, and why quadrupeds, in consequence of their prone position, are not, it affords a strong argument in favor of the Darwinian theory that we were originally quadrupeds—that the posture of our bodies was prone, not upright as now. In view of this predisposing cause, it would appear, then, that hæmorrhoids are alone the heritage of man in his present *exalted* posture." The Doctor might have added that quadrupeds are not subject to inguinal hernia.

SHALL INEBRIATES HANG?—The position taken by a writer in an Eastern journal that "the death penalty as a means of punishment for inebriates (convicted of a capital crime) is opposed by all the teachings of science and experience," is controverted by Dr. Washington Ayer in the *Pacific Medical Journal* for January. Dr. Ayer says "a man is responsible for every voluntary act, inebriety is a voluntary act, therefore a man is responsible for being drunk, and if he become unduly excited by reason of being drunk, he cannot be relieved of the responsibility of any criminal act, save it be in self-defense or in defense of his honor."

BOOK REVIEWS.—Our readers are informed that the Editor of THE JOURNAL is responsible for all book reviews and notices that are unsigned. All such reviews and notices written by others will bear the initial of the author.

THE FRENCH MILITARY MEDICAL SCHOOL.—The French Chamber of Deputies has voted over thirty thousand francs for the school for military sanitation, which is re-organized on a basis which

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includes a contract for six years' army service upon those who have the advantage of a course in the school of military application of medicine and pharmacy.

CHANGES IN PERMANENT OFFICERS.—Dr. Laine has been selected to succeed Dr. Tyrrell as "permanent secretary" of the California State Board of Health. The absence of permanency is troubling the friends of Dr. Tyrrell. The discussion of the ethics involved fills several columns of the *Pacific Medical Journal*.

PROGRESS IN ROME.—According to *Riforma Medica*, a recent decree, authorizes the creation of a Government vaccinal institute at Rome. It will be under the charge of the Direction of Public Health and supervision of a commission composed of the Director of Public Health, a General Army Surgeon, and of the President of the Faculty of Medicine of Rome.

THE *Memphis Medical Monthly* is out in a new cover. The design of the title is neat and appropriate.

DR. HODGHEAD AS AN EDITOR.—D. A. Hodghead, A.M., M.D., has succeeded to the editorial and business control of the *Pacific Medical Journal*, and greets his new constituency with a vigorous exposition of the aggressive policy he intends to pursue in the conduct of the paper.

NEW COLLEGE BUILDING.—The new building of the Medico-Chirurgical College and Philadelphia Dental College is to be opened this afternoon.

THE officers of the Medical Society of the District of Columbia for 1889–90 are: President, Dr. C. E. Hagner; Vice-Presidents, Dr. McArdle and Fry; Treasurer, Dr. Franzoni; Corresponding Secretary, Dr. T. C. Smith; Recording Secretary, Dr. S. S. Adams; Librarian, Dr. Mundell; Examiners, Dr. S. S. Adams, G. Wythe Cook, Kleinschmidt, H. L. Johnson and Acker; Censors, Drs. Winter, Frederick and Ober.

OBITUARY.

DEATH OF MRS. GARCELON.—The death of Mrs. Olivia Spear, wife of ex-Governor GARCELON of Maine, is announced. Dr. and Mrs. Garcelon were welcome and familiar figures at the meetings of the American Medical Association, the members of which will be grieved to hear of the demise of this estimable lady.

SOCIETY PROCEEDINGS.

Obstetrical Society of Philadelphia.

Stated Meeting, Thursday, December 6, 1888.

THE PRESIDENT, T. M. DRYSDALE, M.D., IN THE CHAIR.

DR. WM. GOODELL showed a

RECURRENT INTRALIGAMENTARY CYST,

removed without entrance into the peritoneal cavity.

The patient, a lady æt. 31, at the age of 18 had an ovarian cyst removed by Dr. Joseph Schmetter, of New York, who, in answer to a letter of inquiry, was kind enough to write the following description of his operation: "The cyst had no pedicle and was attached with a very thick mass of fibrous tissue to the right side of the uterus. This attachment being very vascular, it was necessary to ligature in several portions the parts representing the pedicle, and to sew them into the incision of the abdominal integuments for the purpose of being able to control the secondary hemorrhage, if any should occur, which in fact took place several days after the operation."

On December 1 Dr. Goodell operated on her. The fistula was first enlarged so as to admit the finger. As this gave no satisfactory information, the incision was lengthened in the old cicatrix to about 4 inches. This revealed a solid colloid tumor about as large as a cocoa-nut. It was firmly adherent to the cicatrix, to the abdominal wall in front and to the left side. When the lateral adhesions were severed a very large amount of pus escaped from the wound, and the hand now entered into a capacious cavity wholly shut off from the peritoneal cavity by walls of thick pyogenic membrane, which at the navel looked like a false diaphragm. Into this cavity the colloid tumor hung, as if it were suspended. That is to say, while its upper and right lateral surfaces were firmly and closely adherent to the abdominal wall, its under or lower surface, free from adhesions, projected into the fluid of the abscess cavity. A short and slender pedicle, running from the lower end of the tumor, was lost in the pelvic floor of pyogenic membrane. Where this pedicle ended it was impossible to discover, as not a pelvic organ could be felt through this thick membrane, but it was closely adherent to the lower abdominal wall, from which it was detached before being tied and cut.

The tumor was now cut open and its size lessened by digging out its contents with the finger-nail. When it was removed free hemorrhage occurred from the broken adhesions. This was checked by Monsel's solution and by the free application of vinegar, a pint of the latter being

poured into the cavity and splashed about the bleeding surfaces. This large cavity was then treated by the capillary drainage of Mikulicz, viz.: by packing it with iodoform gauze.

Since the operation the patient has done unexceptionably well, the temperature being always natural and the pulse not more frequent than it would be in a person so reduced as she is.

In reviewing this curious case it seems to me that the original tumor removed was an intra-ligamentary cyst of the right ovary; that, as he suspected, a small piece of the cyst wall was left in that portion of the broad ligament which was made the pedicle, and sewed into the abdominal incision, and that *pari passu* with the growth of this fragment of the cyst, an abscess had formed between it and its capsule of broad ligament which formed the walls of the abscess. The 4-inch incision into the abdominal wall did not open into the peritoneal cavity, but merely into a vast pus sac. The tumor was therefore a recurrent intra-ligamentary cyst, and wholly extra-peritoneal. The wonder to me is that this lady bore for so long a time so large an abscess without losing her life.

DR. GOODELL also showed an ovarian cyst which he had removed a few hours before, and in which the characteristic green hue of necrosis was marked. Torsion of the pedicle occurred one month ago, characterized by severe pain and emesis. After this the woman gradually failed in health and lost flesh from chronic blood-poisoning. A few hours before the operation an attack of pain and vomiting took place. The cyst was universally adherent to the abdominal wall, intestines and omentum. The pedicle, a very slender and short one, was so twisted as to stop all circulation, the cyst being nourished merely by its adhesions.

DR. GOODELL showed a specimen of what he deemed to be an *Extra-Uterine Fœtation*. A healthy lady æt. 33 had been married thirteen years without conceiving. On November 25 she consulted Dr. Goodell about pelvic colics, irregular hemorrhages, painful defecation and occasional pains running down the left leg. He found a small womb, pushed forward and to the right by a boggy tumor, lying to the left in Douglas' pouch. Diagnosis of extra-uterine fœtation was made and early operation insisted upon. November 29, while she was in his private hospital, a fifth attack of pain of a "bursting feeling" aroused her out of a sleep. This was followed by faintness. About six hours after this attack laparotomy was performed. As soon as the cavity of the abdomen was opened a large amount of black blood, of the consistency of thin molasses, welled out. Several knuckles of intestine were also forced out. The right ovary was sound, but the left could not be discovered. In its place was found an irregular cavity, within which was found a tumor about the size of an egg, containing within its sac layers of coagulated blood. It was attached to the broad ligament, which was tied and cut off. A number of old clots and shreds of fibrin were flushed out of the abdominal cavity. A drainage tube was put in and the wound dressed with iodoform gauze. The tube was removed December 3, and the patient has thus far had an uninterrupted convalescence.

DR. BALDY, who was present at the operation, had cut the specimen open. He said that the mass contained a semi-fluctuant tumor the size of a small egg, and which he felt confident contained the fœtus before it was opened. On being laid open it appeared like a large blood clot, parts of which had undergone degeneration, presenting a mottled appearance. A small portion of normal tube seemed to run directly into this mass and, as it reached it, spread its coats out over the mass. The ovary was nowhere to be found. He believed that the mass was blood clot, but could not explain its occurrence. The fœtus was not found.

On motion of Dr. Baer the specimen was referred to the Committee on Morbid Growths.

DR. JOSEPH PRICE read a paper on

TUBAL DISEASE A PRIMARY CAUSE OF INTESTINAL OBSTRUCTION.

In reporting cases he had repeatedly called attention to the frequency of adhesions occurring between the uterine appendages and some part of the intestines, and his present purpose was to emphasize the importance of recognizing the danger of obstruction of the intestine arising from inflammatory conditions of the pelvic viscera. In the cases operated on the past year, in more than 15 per cent. there were noted "dense, firm adhesions" between the intestines and uterus and appendages, malignant cases not included. In every case, with one single exception, the inflammatory conditions causing the adhesions apparently originated in the uterine appendages. First, as to the form or kind of obstruction likely to occur. The inflamed serous surface of the diseased tube or ovary, coming in contact with a loop of intestine, or an edge of omentum, provokes inflammation there, and with characteristic promptitude these surfaces cohere. If the process is not severe and of slight duration, these adhesions may disappear as promptly as they occurred, by the enormous absorptive power of the peritoneum, hastened by the mild influence of the peristalsis of the bowels. If, however, the inflammation is severe or assumes a chronic condition, these adhesions gain in extent and strength and give rise to all the variety of conditions classified by Treves as "strangulation by bands." In most cases where these adhesions occur there is a history of constipation. It is probably due as much to the pain caused by defecation as to interference by the condition. Again, the pain is often so great as to

mislead the physician into thinking that a more virulent inflammation exists than really does. But the pain is not always proportionate to the amount of mischief. I have seen cases in which a mere omental adhesion has caused most agonizing pain. For instance, I recently saw a case in consultation, a woman who had had the appendages removed for backache some time before, and who suffered excruciating pain, especially on defecation. In this case the only lesion found was the omentum firmly adherent to the original incision. The omentum here was much elongated, and the transverse colon was dragged below the level of the umbilicus. In like manner I have seen the omentum adherent over the entire pelvis, dragging the transverse colon so out of place that a twist or kink of the bowel could be very easily formed. It is not at all rare to find the vermiform appendix glued fast to the uterine appendages, while almost any loop of the small intestines may become adherent to the inflamed pelvic viscera. As I have said, these adhesions vary in extent and density from those that will tear like wet tissue paper to those so well organized that it requires the scissors to release them, and it is not rare in pus cases for the bowel to be almost gangrenous about these points of adhesion and, in fact, to tear through. That adhesions do not cause complete occlusion at the time of their formation oftener than they appear to is no reason for regarding them lightly, for Mr. Treves tells us in the series of cases he studied that the average duration of the interval between the causation and the obstruction was three years; the shortest period being five weeks and the longest twenty-one years. In view of these general considerations it is hardly necessary to insist upon the release of the intestine wherever and to whatsoever extent adhesions exist. For if the surgeon leaves adhesions when he closes the abdomen, he leaves a probable cause of future serious trouble.

Dr. William Goodell said that his experience in ovariotomy led him to say that it is a mistake to postpone the opening of the bowels to a late period. He used to follow the old plan of not giving a cathartic until the eighth day, but he was confident that he had had death result from intestinal kinks, from adhesions, making it impossible for the bowels to be moved. He now gave an aperient or an enema on the fourth day, and earlier if any symptoms such as vomiting and tympanites, present themselves.

Dr. B. F. Baer said that once he had kept the bowels confined after laparotomy, but now he had them moved on the second or third day, rarely as late as the fourth day. Allowing a pint of warm water to flow into the rectum facilitates the passage of flatus and fæces. He had a case four years ago in which very serious collapse occurred at the end of the second day. Stercoraceous vomiting set in and large quantities of flatus were passed by the mouth, but none by the anus. These symptoms were thought to be due to obstruction, and reopening was considered, but not done. The patient recovered, although she did not pass flatus for five days. Should such a case occur again he would open the wound and would have the endorsement of most operators for so doing. Large doses of salines are advised in such cases, but he wondered if there was not some danger of rupture of the bowel in these cases of adhesion after serious operations, and he related a case. Dr. Price had referred to two cases where he reopened the abdomen for pain, and found the omentum adherent to the line of incision. He knew of no better way to prevent this accident than the early use of laxatives.

Dr. Wm. L. Taylor read a paper on

FIXED UTERI.

In looking over his case book he found the remark, "uterus fixed," so often noted, so often underscored, as much as to say "here again," that he fain would ask how many of these cases were, in their inception, recognized as cases of peritoneal inflammation? In a number the note is made, "patient had attack of inflammation of bladder." "Inflammation of bowels" has been of alarming frequency, whilst "congestion of the liver" makes him wonder at the special degree of sensibility of that organ in women. In a series of cases where the lymph deposit seemed to be the most diffused, a positive history of an active and acute inflammatory trouble could not be obtained. There was only the history of a continued abdominal pain and tenderness, dating from an abortion, from heavy lifting, seldom from normal labors, and presumably never from gonorrhœal infection; seldom—I might say never—have I had perfect success in my efforts to trace the cause to this infection. The history of the husbands, as to the existence of a gonorrhœa or gleet, at the time of commencement of pelvic trouble, is, in the vast majority of cases, worse than uncertain. In several of the subacute cases the only ascribable cause appeared to be indirectly, if not directly, the effort to prevent conception. Freedom from the possibility of, at least, paternal cares, leads to an amiable weakness, and coition follows coition in quicker succession than the law of conservatism would recognize, and, plus the menstrual congestions, which now even anticipate, without the restful periods of pregnancy and lactation, congestion and inflammation of the peri-uterine tissues follow. That this is as immediately the cause of the fixed uteri, the thickened and enlarged ligaments and tubes, and tender ovaries, as is gonorrhœal infection, even in prostitutes, I am inclined to believe. Where the deposits of lymph were more localized or larger in quantity, seeming as if it had been poured out quickly, and had by gravity centered

itself around the uterus, there were histories of acute, well-marked attacks of cellulitis or peritonitis. The causes were difficult labors with badly lacerated cervices, these lacerations extending through into the cellular tissue; and also criminal abortions. In these cases, how often traumatism and how often septic poisoning was the exciting cause it is impossible to say. Catching cold while menstruating, falls, and various other accidental causes were among the number. The average physician, as soon as the patient is up out of bed, shakes himself by the hand and says, "I have cured my patient." But he hasn't! There is still the important sequel to deal with, the lymph deposits. In fully three-fourths of all the cases the body of the uterus has become fixed in retroflexion, even in multipara. Just as soon as the uterus feels the stimulus of congestion or inflammation of surrounding tissue, it becomes turgid and heavy, and sinks decidedly lower in the pelvis until the cervix is near the vulvar orifice, and following the curve of Carus, the fundus is retro-displaced. Here it is, as it were, frozen in, fixed immovably. All around it is a mass of inflammatory lymph, becoming more dense and resisting as organization advances. In the centre of this the sound probably indicates the uterine body with a measurement of 3½ inches. The cavity is tender and the cervix softened, congested with venous blood. Now this deposit varies greatly in quantity as the inflammation has been, by judicious treatment or by nature alone, limited or allowed to involve a great extent of peritoneal surface. The possibility of determining the amount of lymph deposit and the degree of fixation by bi-manual examination seems to me to be one of the few certainties in gynecological practice. A uterus which is low in the pelvis and which cannot be raised to the normal line, and a fundus which is retroflexed and cannot be reposited, with the other evidences, bi-manually, of thickening and deposit, cannot but point to the certainty of previous inflammation. A sterile uterus and a fixed uterus seem to be almost synonymous.

The need of shortening attacks of pelvic peritonitis, aborting them if possible, can only be appreciated by those called upon frequently to treat the sequelæ.

If these are thoroughly treated the amount of lymph thrown out is small and probably will be absorbed almost as rapidly as it was thrown out. But we meet a case which was treated by "the other doctor around the corner," and the uterus and its appendages are imbedded and immovable. Now what are we to do? The great object is to get rid of as much of this effused matter as we possibly can. The older and more thoroughly organized this becomes the less chance there is of rapid and complete absorption. So the moral is, commence early. It is going to do one of three things: undergo absorption, break down and form pelvic abscess or become organized, acquiring an adventitious circulation. In a case of recent or comparatively recent deposit he commences treatment by correcting the digestive tract, getting the stomach, liver and bowels in better condition and surface circulation is stimulated by warm baths and frictions. He then gives mercuric chloride, with the iodide, commencing with small doses frequently repeated and gradually increasing the dose and lengthening the time. Locally he relies upon the abdomino-vaginal galvanic current and gentle or more decided uterine massage, as there is great or little tenderness. This uterine massage he prefers in cases of long standing, where the tenderness has disappeared, but still used carefully where there is tenderness, he finds it beneficial. Every other day, or twice a week, make steady pressure upon the fundus of the uterus with the index finger of the left hand in the rectum and upon the cervix and body of the uterus with the right index finger in the vagina. This pressure is kept up for two or three minutes, gradually trying to force the body upwards and forwards. Then efforts at lateral movement for the same length of time. This massage is followed with the continued galvanic current, using the abdomino-vaginal method. For the breaking down of pelvic lymph he has not used electro-puncture, preferring the slower and as certain absorption by the stimulation of pelvic circulation. Where there is tenderness he uses the positive pole in the vagina and the negative over the abdomen for the first three or four applications and it is marvelous how rapidly this tenderness disappears. He then reverses the poles, using the negative with a ball or small crescent-shaped electrode in the vagina. These *séances*, including the massage, last for about fifteen or twenty minutes. The strength of current averages about 25 to 30 milliampéres. After this is over he frequently packs the fornix with wool, introducing a small ring pessary to keep the wool as much as possible in position. After he gains a certain amount of mobility he introduces a Smith-Hodge pessary, small at first, increasing to a more suitable size as the uterus rises to the normal line. Tincture of iodine to the fundus of the vagina.

DR. T. HEWSON BRADFORD read

NOTES OF GYNECOLOGICAL CASES TREATED BY ELECTRICITY.

DR. B. C. HIRST thought it was a gratifying fact that we were advancing in this branch of therapeutics. It seemed that for a time we did lag behind other gynecological centers. He tried electricity some time ago but with very little result, because he had, he thought, used too weak a current and because he did not thoroughly un-

derstand the application of electricity in gynecology. He thought that much of the criticism of this kind of treatment had been ill-considered.

(*To be continued.*)

Gynæcological Society of Boston.

Regular Meeting, Sept. 13, 1888.

THE PRESIDENT, HORACE C. WHITE, M.D., IN THE CHAIR.

A letter was presented by the President from Dr. Herbert J. Harriman resigning on account of ill health, his position as Secretary of the Society which he had held for nearly four years. The resignation was accepted and it was unanimously voted that "the thanks of the Society be extended to Dr. Harriman for the able manner in which he has acted as Secretary."

DR. F. L. BURT presented some curettings of the uterus with the following history: The woman, æt. 67 years, had suffered from uterine hemorrhage for five years, during which time she had obtained temporary relief three times, after as many operations by different doctors. Last November Dr. Burt operated, removing by the curette about one-fourth pint of material from the interior of the uterus. This was pronounced to be adenoma. This operation again gave temporary relief, and it was repeated last May, when about the same amount of material was removed; but this time it was found to have undergone carcinomatous degeneration. Total extirpation of the uterus was performed, after which the patient recovered. The uterus was exhibited.

A pus-sac was then shown which had been removed by laparotomy from another patient.

The paper as announced for the meeting,

ANTISEPTICS IN GYNÆCOLOGICAL AND OBSTETRIC OPERATIONS,

was read by Dr. F. L. Burt.

DR. A. P. CLARKE said that he had long ago given up the use of the sponge-tent, believing it to be unsafe. Iodine is a good antiseptic, but corrosive sublimate is the most powerful of all. Less of it is needed, however, if alcohol has been used to bathe the parts previously, *e.g.*, on the abdomen previous to a laparotomy. One of the objections to corrosive sublimate is its decomposition by albumen, with the formation of albuminate of mercury. The doctor thinks we should all have some ideas concerning the use of antiseptics and carefully apply them. Dr. C. has introduced the sound a great many times, and has taken pains to have it antiseptic, and he uses iodine afterwards to lessen the danger from introduction of germs. Intra-uterine injections have proven unfavorable, as a rule, in his hands, and he believes that there is danger of forcing air into the Fallopian tubes.

DR. WM. G. WHEELER said that we are apt to overlook other things when considering antiseptics, *e.g.* drainage, which the reader had not mentioned at all. Drainage is important. We must be careful not to shut up the enemy in trying to bar out the germs.

DR. R. E. BROWN asked what precautions the reader recommended when examining a woman during labor? (Answer by Dr. Burt: Hot water and soap are often sufficient, but we may need corrosive sublimate besides.) Dr. Brown said that he always washes his hands thoroughly and then dips them into a solution of corrosive sublimate. He had lately delivered a woman of a child which had been dead some time, and there was no trouble afterwards.

DR. W. O. HUNT said that he wanted to emphasize *antiseptic midwifery*. Cleanliness is the most important thing. It is necessary to scrub, not simply dip, the hands in corrosive sublimate solution. For a lubricant he prefers a solution of corrosive sublimate 1 to 2000 in glycerine. He considers the pad a great comfort. These are made by the nurse, who folds up a considerable quantity of salicylic cotton in a square of cheese cloth, and then bastes it to keep it intact. Next the vulva he places a small piece of absorbent cotton, which has been dipped into corrosive sublimate solution. The nurse should never touch the patient without having first previously used the solution of corrosive sublimate. We should not then see the temperature rise. Dr. Hunt never uses the vaginal tampon.

DR. C. W. STEVENS said that he had solved for himself the question of carrying antiseptics safely and in a convenient form. Carbolic acid cannot be carried without the risk of injuring the bag, but he always has with him salicylic acid and corrosive sublimate. For the salicylic acid he carries a small box which contains just 7½ grains, and this added to a pint of water makes a solution 1 to 1,000. This solution he uses for the instruments requisite for suturing and for the obstetric forceps. The corrosive sublimate he carries in the form of tablets, one of which, added to a quart of water, makes a solution 1 to 2,000. Into this, after diluting, he dips a clean napkin, which is then wrung out as dry as possible, and placed, while still moist, against the vulva. The patient finds this comfortable and likes it as well as the pad. He also carries corrosive sublimate soap which makes a good lather.

DR. ESTHER HAWKS remarked that many patients cannot supply themselves with the materials that have been advocated, and moreover, among the poor patients there is generally no nurse to carry out such instructions as have been given. Water and soap, however, can always be obtained,

and frequently it is necessary to get along with these alone.

DR. W. SYMINGTON BROWN said that he believes corrosive sublimate to be a highly dangerous compound. It coagulates albumen in strong solutions and hence weak solutions are more dangerous. Some cases of dysentery and even death are known to be due to its use. Iodine is an excellent antiseptic, and it is safe. It may be used dry by putting it into a bottle with wool, and the iodine will evaporate and be deposited in fine particles on the fibres of the wool. Cleanliness, however, is the thing that is needed.

DR. SAMUEL N. NELSON said that he had seen only good resulting from the use of the continuous suture of catgut, or better, of tendon, and particularly when it has been used as a bruited suture. This he has assisted Dr. Marcy in using for the past seven years, and it is especially adapted for coaptation after amputation of the breast, for repair of the perineum, for union of the abdominal walls after laparotomy, for radical cure of hernia, and in a great variety of other operations, not of a special gynæsic type. For its successful employment thorough antisepsis is needful. It is important that the suture should not be drawn too tightly, nor in fact is more than approximation and retention necessary as a rule; for plaster lymph glues the parts together in a remarkably short time.

Of the antiseptics corrosive sublimate is the most powerful, but the fact that it forms an insoluble compound with albumen is somewhat to its disadvantage. Similarly, soap renders a solution of corrosive sublimate somewhat inert. In midwifery Dr. Nelson has been accustomed for some years to use a solution of corrosive sublimate (1 to 1,000) for the hands and for the napkins in the manner just described by Dr. Stevens. This he thinks highly important and safe, although he always requires the solution to be marked POISON and to be kept on a high shelf away from access by children.

DR. HORACE C. WHITE said that we should make a distinction between natural labor and that which requires interference. He has no patience with obstetricians who interfere with the course of labor merely to save time. Unless there is some special reason the vulva should not be opened. If the case requires surgical interference, different rules should govern it. He thinks that heat is an excellent antiseptic, and he has been accustomed, after thoroughly washing his hands, to hold them in the blaze of an open fire if possible. Diluted alcohol is a good antiseptic.

THE meeting of the American Medical Association at Newport, R. I., promises to be the best in its results, and to have the largest attendance of any yet held.

Medical Society of the District of Columbia.

Regular Meeting October 10, 1888.

DR. SWAN M. BURNETT, VICE-PRESIDENT, IN THE CHAIR.

DR. LAMB presented specimens illustrative of

TYPHOID FEVER, WITH NOTES OF CASES AND AUTOPSIES.

A dark mulatto girl, æt. 15, died September 25, 1888, after being in hospital but four days, and as nearly as could be ascertained, at about the tenth day of typhoid fever. I made the post-mortem examination and found about twenty dark spots, most of them one-eighth inch in diameter, on the abdomen. The brain was normal, but the pia mater congested. The lungs were congested, the heart appeared normal. A lumbricoid worm in the œsophagus. Bloody mucus in larynx and trachea. The liver was removed; but the gall bladder contained forty-two gall stones, the specimens shown at our last meeting. The spleen was large, dark and soft. Pancreas and stomach appeared normal. The ileum showed characteristic enlargement of Peyer's patches, and solitary follicles. The colon was generally congested, and the solitary follicles somewhat prominent. The mesenteric glands large and hyperæmic. The kidneys pale. Bladder full of urine. The right ovary converted into a cyst the size of a small walnut. There was no evidence of the menses having occurred.

This, then, was quite a typical case of typhoid fever.

On the 7th inst. I made a post-mortem examination on the body of a negro, æt. 27, who died rather suddenly, and therefore came under the coroner's notice. The friends said he had been sick for several days, but was walking about the day before death. The head was not opened, but the fauces and pharynx showed congestion and glandular enlargement, the tonsils being especially prominent. The tongue tip was held firmly between the teeth, as if in a spasm.

Larynx, trachea and bronchi contained mucus and granular matter. There was a large mass of greenish mucus pus under the vocal cords. The lungs were much congested. The heart flabby and filled with dark blood and soft black clots; there were abundant ecchymoses under the pericardium. The liver and spleen were congested. The peritoneum hyperæmic. Peyer's patches and the solitary follicles of the ileum were slightly thickened, while the mucous membrane was markedly hyperæmic. The mesenteric glands were also enlarged and hyperæmic. The kidneys large and somewhat congested. Bladder full of urine.

This also was a case of typhoid fever, but at an earlier date, perhaps not more than three or

four days of the disease. The lesions quite typical. The two cases are put side by side for contrast.

A very interesting point in the second case was the cause of death. I have grouped together (1) the matter of the tongue having been held spasmodically between the teeth; (2) the mass of mucus adjoining the vocal cords; (3) the very marked congestion of the lungs; (4) the flabby heart, filled with dark blood and clots; (5) the dark condition of blood generally; and (6) the supercardial ecchymoses; and have concluded that there is a strong suspicion that the woman may have been strangled by the mass of mucus, which afterward slipped backward in the relaxation of the spasm.

DR. LAMB said that he was aware that the cause of death, in the second case (asphyxia), might be assailed. But the ecchymoses of the pericardium, to which he had failed to allude in his notes, also pointed to death from suffocation.

DR. EDES asked whether the heart showed fatty degeneration?

DR. LAMB in reply stated, that there was no fatty degeneration, the heart was such as we found in typhoid fever. He asked whether typhoid fever was prevalent at this time in the city.

DR. C. W. RICHARDSON read a paper entitled:

PATHOLOGICAL CHANGES AT THE BASE OF THE TONGUE, POSSIBLY EXPLAINING CERTAIN SO-CALLED FUNCTIONAL DISEASES OF THAT ORGAN.

(See page 119.)

DR. BERMANN said, the paper brought back a number of cases, in which pins had been swallowed and located by the patient in the pharynx or œsophagus. He must confess that he had never seen a case of hemorrhage such as described, and had ascribed the symptoms to hysteria. The first case given by Dr. Richardson vividly recalled a case of his own. A young married lady came to his office and stated that she had swallowed a pin in some apple sauce. She complained of pain at the back of her tongue, and declared that she felt the pin. He examined carefully the pharynx and posterior nasal cavities, but found no pin; but there was decided congestion of the larynx. After a good deal of trouble he finally convinced her of her mistake by letting her look for herself. As many throats as he had examined, he had never seen a hemorrhage of the kind described in the paper. It perhaps bore a relation to purpura hemorrhagica, which, as we know, presented itself in hemorrhagic spots of a painful character over different parts of the body, shifting their position quite frequently. The true explanation of their occurrence had not as yet been given. Dr. Richardson's cases were perhaps similar ones.

DR. RICHARDSON said the fact that the condition had never been seen before did not militate against his observations. He had never before seen it.

DR. TONER said he would like to speak of the tongue as an organ in the perpetration of fraud. In an institution for females of which he had the charge, a patient presented a black tongue, greatly exciting the sympathy of all around her. A careful examination revealed no other symptom except the abnormal color. Taking the handle of a spoon, he scraped the whole black mass off without difficulty. He then expressed his suspicion to the superiors that the patient was committing a fraud, and advised that precaution be taken to either verify or contradict his suspicion. It was then discovered that the girl took stove-blacking to produce the result. A physician of Frederick, now dead, thought years before his death that he had swallowed a fish-bone, which had remained in his throat for years. So convinced was he of this, that he had himself examined in Frederick, as well as in Baltimore, by the most eminent specialists. Dr. Toner had examined him here, and agreed with all the rest that there was no foreign body in his throat. In this case he thought there was an affection of the nerve centres, for the patient died suddenly of brain trouble.

DR. HOEHLING spoke of the case of a lady whom he saw five years ago, and who declared that she had inhaled a thread while biting it off in sewing. She could not be convinced to the contrary, though no thread could be found. She suffered from hysteria, for the cure of which she underwent the operation of trachelorrhaphy, but without beneficial result as to the hysteria.

Regular Meeting October 24, 1888.

DR. L. L. FRIEDRICH presented a patient with *Lupus Vulgaris of the Face and Leg.*

DR. D. S. LAMB presented

A DOUBLE MONSTER, WITH REMARKS ON THORACOPAGUS.

(See page 118).

DR. LAMB also presented a specimen showing

AN ANOMALY OF THE STERNUM AND RIBS.

DR. LAMB stated that an eighth sternal rib was exceedingly rare. The French did not report any; the Germans only two; one in England—that of Humphrey; and that of Allen, in America. Dr. Lamb explained the fact of its not being mentioned more frequently in literature upon the theory of race peculiarity. All the American specimens were from negroes, except one from an Indian. An eighth sternal rib must bear some relation to respiration. The anomaly occurred in both men and women. It would be interesting to inquire into such peculiarities.

DR. A. F. A. KING had given very little attention to monstrosities. He would exhibit a case of coalition of the faces of a monster, at the next meeting. He supposed the development had been in one of the ways mentioned by Dr. Lamb.

DR. SCHAEFFER said this subject could be studied by observations upon the vegetable world. It is more than probable that in such cases there is more than one spermatozoon. We cannot judge of the anomaly of development from the specimens in the Museum. Some time ago Dr. Bayne asked him to see an an-encephalous child. Its head receded above the brow and it had a hare-lip. It was alive and was very repulsive as it breathed. Its parents would not allow it to be exhibited and so buried it. Dr. Lamb had mentioned heredity as bearing an important relation to such monstrosities, but forgot to say anything about consanguinity of parents. In Bayne's case the parents were first cousins, but presented very few similar traits either of person or disposition. The mother had a forboding that something would be wrong. The second pregnancy was a miscarriage. He asked Dr. Lamb if consanguinity had ever been looked on as a cause of monstrosities.

DR. LAMB: Experience and observation have shown that consanguinity has less influence in the productiou of such interruption of development than was formerly supposed. All authors are now of the opinion that twin, triple and quadruple monsters are from one ovum.

DR. J. FORD THOMPSON reported two cases in which he had removed

SUPERNUMERARY FINGERS AND TOES.

Two years ago he operated on the first case and removed the supernumerary fingers. A short time ago he removed the supernumerary toes from the sister of the first patient. He obtained the history of this peculiarity in two other members of the same family; the members had been tied by physicians and fell off. He thought it quite remarkable that there should be four similar cases in the same family. He thought heredity had a great influence in such false developments. Eight years ago he had operated on a child for hare-lip with success. He had been recently called to a child of the sister of this patient who had a hare-lip worse than that of the first case. In the latter the vomer projects beyond the nose. There were two cases in this family, but he could not trace it any farther back. He did not think that maternal impressions had any influence on such deformities, as the development was too far advanced, especially in hare-lip and cleft palate, from the period when the impression is said to be received.

DR. KLEINSCHMIDT desired to make an addendum to Dr. Lamb's remarks, by stating that twins coming from *one* ovum were always of the same sex; hence, joined monsters coming as they did from one ovum, were always of the *same* sex.

STATE MEDICINE.

Sanitary Convention at Hastings, Michigan.

REPORTED FOR THE JOURNAL.

A sanitary convention, under the auspices of the State Board of Health, was held in Hastings, Michigan, December 3d and 4th. The five sessions were well attended, and the interest seemed to increase to the close. On each subject there was a paper or address, followed by discussion. The subjects discussed were those which should and did interest the citizens, and included "The Water-supply of Hastings," "The Disposal of Excreta and Waste in Hastings," "Plats of Localities in Hastings"—showing exact relative positions and distances between wells, privies, etc., "The Prevention of Communicable Diseases," and the "Duties of the Local Health Officer." This last subject was treated by D. E. Fuller, M.D., himself the local health officer, and by Henry B. Baker, M.D., Secretary of the State Board of Health. Dr. Baker pointed out how lives and money can be saved in a locality by the appointment of a health officer, if the people and the health officer will co-operate for the restriction and prevention of scarlet fever, typhoid fever, diphtheria, etc. He showed how at least one physician in a village or small city can be employed to prevent instead of cure disease, with pecuniary profit to the people and at least a salary to the physician of not less than one thousand dollars a year. His paper was substantially as follows:

Inasmuch as our health officers exist for the purpose of protecting us from dangerous diseases, we may get an idea of what are their most important duties by finding out what are the most important dangers from which they should protect us.

In Michigan, the five diseases which cause the most deaths are: Consumption, diphtheria, typhoid fever and scarlet fever.

DIPHTHERIA.

Concerning diphtheria, which is next to the most fatal disease, health officers in Michigan now generally know how to restrict it, and thereby to save hundreds of lives. If you ask how do we know that they know how, I reply, some of the health officers in Michigan are doing this all the time, and we have the facts to prove it; and to prove how it is done. For instance, in 1886, 461 outbreaks of diphtheria were reported to the office of the State Board of Health, and the health

officers were requested to report just what was done to restrict the disease, and how many cases occurred in each outbreak. If under one method of work or neglect to work the disease spreads, and under some other method of work the disease does not spread from the first cases, we can find it out if we devote sufficient thought and work to the compilation of the reports which the health officers make, provided they report the exact facts. I am sorry to say that in about 240 of the outbreaks the health officers did *not* report with sufficient accuracy so that we could tell exactly what they did do; but in about 200 outbreaks they *did* report distinctly, and, of these about one-half had secured isolation of the first cases and the thorough disinfection of infected things, while the other half had not secured both isolation and disinfection, although some of them had secured one or the other of these important measures. Careful compilation of all of these reports showed that in those outbreaks in which either isolation of the sick, or disinfection of infected things had been neglected, the disease had spread so that there were five times as many cases, and five times as many deaths as there were in those outbreaks in which both isolation of the sick and infected, and the disinfection of all infected places and things has been accomplished. In the 116 outbreaks in which all this was done there was apparently a saving of about 300 lives and 1,500 cases of sickness from diphtheria. Of course it is easy to find fault, and to say: "What a pity these measures were not carried out in all of the 461 outbreaks instead of only in the 116," but we should not lose sight of the fact that there was a positive saving of several hundred lives in a single year, from one disease, and that the compilation of the reports proved how it was done, and how it might be done again, namely, by thorough and careful isolation and disinfection under the direction of a capable and efficient health officer. And now very much the same thing has been done again, as is shown by the compilation of the reports of the health officers in Michigan for the year 1887.

SCARLET FEVER.

What I have said relative to diphtheria is applicable, with slight variation, to scarlet fever. The compilation of the reports of the health officers in Michigan relative to scarlet fever during the year 1886, showed that in the fifty-eight outbreaks in which disinfection had been thorough, the disease had not spread much, while in those outbreaks in which isolation or disinfection had been neglected there were over five times as many cases and over five times as many deaths. The compilation of the reports relative to scarlet fever in the year 1887 has demonstrated that the year 1886 was not exceptional, the saving of life and health was again apparent.

TYPHOID FEVER.

The measures for the restriction of typhoid fever are not the same as for diphtheria and scarlet fever, and the evidences of success have not yet been so well elaborated, but I feel confident that a considerable proportion of the sickness and deaths from this disease may be prevented, by measures which are described in a pamphlet, copies of which are distributed in this audience. Some of the essential measures need the efforts of the health officer to make them more effective; but in all of these diseases the co-operation of the people with the health officer is important.

WILL IT PAY TO HAVE A HEALTH OFFICER?

It is plain, then, that some of the most fatal diseases that affect us may be in great part prevented, and that much depends upon the knowledge and efficiency of the local health officer.

It is plain, too, that the measures by which these diseases are prevented are *not* those which in old times we associated with the duties of the health officer. The abatement of ordinary nuisances should probably be attended to by the health officer; but the abatement of nuisances may have very little to do with the prevention of diphtheria or scarlet fever; while it is certain that *isolation and disinfection* of *infected persons* and *things*, *will save lives*.

But when the health officer comes into very close relations to cases of some of these dangerous diseases, he must himself refrain from going directly to some child to whom he may carry the disease; and so he must lose his practice. He will also lose much by the antagonism of those whose movements he will cause to be restrained. Consequently, whenever there is an outbreak of one of these diseases, if he attends to his business as health officer, it is probable that he must relinquish his other means of income. Is the public prepared to guarantee him, say, ten dollars a day during the outbreak? Is the public prepared to ensure him against loss by reason of his necessary action as an efficient health officer? If not, is the public willing to give him such a fixed salary as will induce the health officer to take his own chances of loss?

My belief is, that, except in Detroit and Grand Rapids, there are few, if any, cities or villages in the State, where these questions have been properly met in the interests of the people. Therefore, either the health service is not what it should be, as is the case in many places, or it *is* what it should be, simply through the public spirit or philanthropy of some physician, as I am glad to testify is the fact as regards many of the cities and villages in Michigan.

Perhaps you may think I am wandering from the subject of the duties of the health officer and am giving a rather broad hint as to the duties of the people or their representatives to properly

support the health officer; but it is necessary to examine into the question in some such manner, in order to see how it is possible to have a health officer who can afford to perform his duties faithfully. Taking into consideration the prospective losses in various ways, my own view is, that no physician can afford to file his oath of office in the city of Hastings, unless he is assured of a salary or compensation averaging a thousand dollars a year. Can the City afford to give that much? Let us examine into the facts.

MANY LIVES MAY BE SAVED AND MONEY TOO.

The population of Hastings is about three or four thousand. If its death-rate is about the average, the annual deaths number about sixty. Then about seven or eight of these are from consumption, about five from diphtheria, about two from scarlet fever, and about two from typhoid fever. These numbers may not be exactly true for last year, but for a long series of years they are an approximately true average.

From the experience of the health officers in Michigan during the years 1886 and 1887, I have demonstrated that at least 80 per cent. of the cases of the sickness, and 78 per cent. of the deaths from diphtheria are prevented by those who secure, after the first case has occurred, complete and thorough isolation and disinfection, such as an efficient health officer can secure when his people co-operate with him for that purpose. Therefore, the lives of at least four persons in Hastings can be saved each year, on the average, from that dreadful disease diphtheria. There may be single years when diphtheria may not come to Hastings and then some parsimonious grumbler might wish to cut down the salary of the health officer, perhaps after the same health officer had in some way prevented the first case being brought in, as, for instance, by preventing a public funeral over the body of one dead from diphtheria, and brought here for burial; but I think you can be assured that, in these days of rapid transit and constant movement among the people, Hastings is in *danger* of having diphtheria brought here every year, and you need a health officer constantly on guard and in close correspondence with the central office at Lansing, so that, at a moments notice, he may take action to prevent the introduction, or if that is impossible, then to prevent the spread of this, one of the most dangerous diseases to which our children can be exposed.

LIVES MAY BE SAVED FROM SCARLET FEVER.

Then, too, nearly the same remarks apply to scarlet fever as to diphtheria; although in recent years the deaths in Michigan are not so numerous. Yet, taking the average of years in Hastings, at least one death per year from scarlet fever should be saved by prompt and thorough action, even after the disease has been introduced, and, of course, the most important service of a health officer is to prevent the introduction of such a dangerous disease.

CONSUMPTION SHOULD BE LESSENED.

Enough is now known of the causation and spread of consumption, so that this most important cause of death should be very greatly lessened; and it may be lessened by spreading among the people information concerning its causes and just *how* it may be in great part prevented. An intelligent and faithful health officer, whose time was not otherwise demanded for the practice of medicine to support his family, might do much to put before the people whom he was adequately paid for guarding, the facts collected by sanitarians and State Boards of Health, which would enable them to guard against this disease, which is so fatal to people at those ages at which they should be in the prime of life. At least one death per year in Hastings should be saved from consumption.

LIVES MAY BE SAVED FROM TYPHOID FEVER.

Some one, familiar with the ways in which typhoid fever is spread, has said that for every death from typhoid fever some person should be held criminally responsible. I should not agree with that, because I think that, among a large proportion of the people, the ignorance, which still permits the disease to spread, should be pleaded in extenuation. But intelligent health officers can inform the people under their care how to restrict the spread of typhoid fever, and how to do many things which tend to prevent the occurrence of the first case in a community. At least one death a year in Hastings from typhoid fever ought to be prevented; and the person saved would be most likely to be in the middle age when his work would be most productive.

Thus an efficient health service, having thorough co-operation of the people, should save in Hastings each average year seven lives, five of the persons being children and two grown persons. I do not say positively that exactly so many were saved during the past year, but I do claim, that on an average, this number can be, and should be, saved over and above what would occur without such efforts as those I have suggested. I claim that the health officer should earn and have a thousand dollars a year, to supervise the work, and that all of your people should aid him whenever it is necessary, and that expenses should be incurred by the city and by individuals which might aggregate another thousand dollars; and that your people would not only save those seven valuable lives of children and friends most dear to you, but that, by this outlay, money would actually be saved which otherwise is lost; that is, if the money were judiciously expended and you secured the efficient service which I have indi-

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cated. Let me point out just how some of the saving would occur:

THE MONEY VALUE OF WAGE WORKERS.

Political economists sometimes estimate that an average man in the early part of the productive period of his life will afterwards earn, over and above what it will cost to support him, one thousand dollars. It is within the memory of some of us that a healthy negro slave could be sold at the south for eight hundred or a thousand dollars, and we will all admit that slaves were not the most industrious persons either. Now if we save from death, and in good health, two adult persons in Hastings in each year, we have saved in money value to the families to which those persons belong probably the full amount of the two thousand dollars a year, which I advise you to spend on your health service. Then there are the five children which are saved from diphtheria and scarlet fever. They have cost hundreds of dollars for their maintenance, and if they die all is lost, but if their lives are saved they will soon reach the productive age. They are worth to their families, for what they will cost and earn—say one-fifth of the value of an adult person; or another four thousand dollars which we may look upon as profits on our two thousand dollar investment. A 50 per cent. profit ought to satisfy any tax payer in the city. And if one of these children chanced to be your own, or the adult the bread-winner of your own family, the arguments should be convincing; but there is another alternative suggestion which is illustrated by a remark that I recently heard at the meeting of the American Public Health Association: Dr. Smart, of the U. S. Army, was deploring the slowness of the people in public-health work, and said there was little comfort to be had from the thought that years in the future when your name is mentioned, some one will say: "Yes, I knew him well; he died, prematurely, eight or ten years ago of typhoid fever." Well, precisely that may be said of any one of us, because the safety of each one is bound up with that of others; no man lives to himself alone; not only is he his brother's keeper, but his brother, his fellow citizen, and even a person in a foreign land may send him something, or do that which will endanger his life. In fact, I suppose that all of our dangerous communicable diseases are brought to us—we do not create them, and much can be done by ourselves, by our families, by the community, and by the health department of our local government (which exists for our common safety and welfare) to protect us from diphtheria, from typhoid fever, and from the other dangerous diseases which may be prevented or restricted.

Attend the next Annual Meeting.

DOMESTIC CORRESPONDENCE.

Medical gentlemen writing to the Editor of THE JOURNAL will please conform to the rule requiring MS. to be written on one side of the paper, to take pains to write the names of persons and places legibly, and to send their own names as a guarantee of good faith.

Should Syphilitics Marry?

To the Editor:—Some questions that are not clear to my mind in the light of my present knowledge.

1. Is syphilis a curable disease? or is it possible to eradicate all the syphilitic germs from a syphilitic? 2. Is not a person once a syphilitic always a syphilitic? 3. Is the germ of tertiary syphilis the same as the germ of secondary syphilis, and also the same as that germ which causes chancre? or is their virulency modified by removal from the chancre? 4. Is it possible to inoculate a non-syphilitic by serum or secretions from a tertiary syphilitic and produce a syphilitic chancre? 5. Should syphilitics marry? and when?

In the light of my present knowledge I believe syphilis is not entirely a curable disease. Whilst it may be modified by specific and timely treatment, I believe it is impossible to eradicate completely all the germs in a syphilitic, so that I think that a person once a syphilitic is always a syphilitic. A syphilitic may seem to be to all intents and purposes cured of the malady, yet it is apt to make its imprint manifest on some of his or her children.

I believe the germ that produces chancre is the same, and has the same virulency, as that which circulates in the system during secondary and tertiary syphilis, and so long as there is a single syphilitic germ in the system such a person is a syphilitic and may convey the disease to others in various ways. For that reason I would say a syphilitic should never marry. It would be better for the State that he never married. It has been my experience that a syphilitic, no matter in what stage, or how completely cured he seems to be, is liable to inoculate his wife with the disease, or some of his children may inherit it.

From what I have said, I am induced to produce the following cases of the many that have come under my observation.

P. Q. contracted syphilis when he was 25 years old. Married at the age of 34 years a perfectly healthy blonde of 21 years of age. When he married he had not undergone any regular treatment, but was in every way, so far as appearances indicated, a perfectly healthy man, except a leaden appearance that he presented. His kidneys and liver often become torpid. He is strictly a temperate man and takes exceedingly good care of himself. The wife has one child by him, a boy nearly 5 years old. The child is apparently healthy and fat, and large of his age. Whilst carrying the child the mother presented the char-

acteristic symptoms of secondary syphilis, which was either conveyed to her from the father through the child or from the semen of the father. Mrs. P. Q. weighed 125 pounds when she was married, but was afterwards by the effects of the disease reduced in weight to 105 pounds. The child has not as yet presented any indication of having inherited the disease.

B. R., a young man of scrofulous diathesis, inherited from his father, who had had syphilis. B. R. contracted syphilis, after he had had a very bad ulcerated leg, when he was 20 years old. I treated him specifically for two years. He married a blonde 21 years of age when he was 25 years of age, and now has two children by her, who are apparently healthy. The wife so far has also escaped the disease.

A. B., a young woman æt. 21 years, contracted syphilis and underwent a mercurial form of treatment for one year, after which she was married and had two children, a boy and a girl, now respectively 16 and 18 years of age. They appear to be entirely healthy, although in childhood they presented the characteristic symptoms of inherited syphilis, and were so treated. The mother has since died with syphilitic disease of the liver.

A. R., a young man æt. 25 years, contracted syphilis and was treated with mercury for two years. He then married and the first child was a still-born, having died *in utero* and become macerated before birth. Whilst carrying a second child Mrs. A. R. was treated with mercury, and the second child was born alive and is still living. She has had several children born alive since that, all are now living and apparently well. The mother never contracted the disease from the husband.

J. P., a young man æt. 21 years, contracted syphilis. He was treated with mercury two years. He married at the age of 25 years. His wife bore him three chilnren; one died soon after birth, of imperfect development of the heart, and the second died during the second summer of inherited syphilis, but the third is still living and apparently healthy. The mother does not show any symptoms of the disease.

A young man contracted syphilis when he was 18 years old and was treated with mercury for two years. He then married and had one child. The child has symptoms of having inherited the disease, although the father and mother are apparently healthy.

A man married a woman suffering with tertiary syphilis. The husband contracted the disease from the secretions of his wife in the form of a chancre in the urethra or that of a gonorrhœa. The husband never had any buboes, but had all the symptoms and evils of the dread disease.

I have said syphilitics ought not to marry: as far as the disease in my opinion is a curable one I would adhere to my stated opinion. If it could be cured in such a way that there would be no possible chance of transmission I would say marry, but my experience and observation have taught me that syphilis is not a curable disease and is oftener than otherwise transmitted to posterity, even when it has received a scientific and prolonged treatment. If also with the view of final eradication of the effects of the disease from the posterity of a syphilitic by proper selection I would say marry, for I believe it is only through proper selection and for a long time that the effects of syphilis can be finally eradicated from the posterity of a syphilitic.

JOHN M. BATTEN, M.D.

Pittsburgh, Pa., Jan. 12, 1889.

Should Antipyrin be Used During Parturition or Gestation?

To the Editor:—During the last year or two I have quite frequently noticed in current medical literature references to the beneficent influence exerted by antipyrin in modifying the pain and suffering of labor. In one case in my own practice I administered it with decided advantage, the suffering being much mitigated, and were it not for one question that presented itself to me, would have used and continue to use it frequently. The question to which I refer is this: May not the influence of the drug in inhibiting or suppressing the secretion of the milk more than counterbalance all advantages derived from it as a pain obtunder?

How much influence it exerts over the lacteal secretion has not as yet been clearly determined, but I have recently seen in the medical journals a number of laudatory notices of its marked effect in suppressing milk secretion. In the *Medical News*, of Dec. 8, 1888, page 645, T. Haven Ross, M.D., reports a case in which it exerted a marked influence and gives reference to other journals corroborating his experience. These facts I deem of sufficient importance to put every physician on his guard against an indiscriminate use of the drug as a pain alleviator during parturition and lactation, at least until it has been definitely decided how much influence it does exert upon the lacteal flow. The percentage of American women who nurse their infants without any assistance from artificially prepared foods, is not so great as to justify physicians in administering a lactifuge for the many rheumatic, neuralgic and other pains for which this remedy is now so universally used. Let those who have abundant clinical facilities elucidate this question so that all physicians may be able to use the remedy intelligently and subserve the best interests of their patients.

E. STUVER, M.S., M.D.

Rawlins, Wy. Terr.

The Choice of Five Journals.

To the Editor:—I have not received THE JOURNAL of the 12th inst. as yet. Is it the fault of the mailing clerk, or of the mails? I cannot afford to miss a single number of THE JOURNAL, as it is my choice out of the five weekly journals that come to my office. Please send me the one of that date, and oblige, Yours truly,

T. C. KENNEDY, M.D.

Shelbyville, Ind.

The San Francisco Coroner.

To the Editor:—In connection with an item on p. 885, of the issue of Dec. 22, of your esteemed journal concerning the Coroner of this city, allow me to remark that the then incumbent is a medical man, and that the non-medical coroner is for once not at fault. Yours truly,

OBSERVATORE.

San Francisco, Cal.

NECROLOGY.

Robert McLure Fairleigh, M.D.

DR. ROBERT M. FAIRLEIGH was born in Brandenburg, Meade Co., Ky., on January 17, 1840, and died at his residence in Hopkinsville, Ky., on October 19, 1888, being in the 49th year of his age. He studied medicine under Dr. H. K. Pussy, of Garnettsville, Ky., and graduated in the class of 1860 of Jefferson Medical College, Philadelphia, some months before he attained his majority. At the beginning of the Civil War, when under 22 years of age, he was appointed Assistant Surgeon of the Third Kentucky Regiment, U. S. Army. Though very young, and of course without experience, his natural talent for surgery as demonstrated by his skill when it was demanded, and his devotion to the sick under his charge, caused him to be promoted in June, 1862, to the rank of Surgeon of his regiment, which position he continued to fill with ability and satisfaction until the termination of the War, when he was appointed Medical Director of the Western Department of Kentucky, with headquarters at Bowling Green, where he married Miss Annie Slaughter, of Lane Co., Ky., on May 17, 1865. In July, 1865, he resigned his commission in the Army and moved to Hopkinsville, Ky., where he immediately engaged in general practice, and where he continued to live and labor in his profession up to a few weeks before his death. During the twenty-three years of his residence in Hopkinsville he found but little time for recreation; being devoted to his profession and the welfare of his patients, his services were in constant demand from a large clientèle. He was a member of the Kentucky State Medical Society, of the McDowell Medical Society and of the Christian County Medical Society; was President of the latter and for several years its Secretary. He was eminently progressive and public-spirited, as a member of the Board of Councilmen of his adopted city. He inaugurated many measures for the public good.

As a general practitioner Dr. Fairleigh had few superiors. As an old patron said of him, he was prompt, skilful and safe. As a surgeon he was dexterous, but eminently conservative, ever striving to avoid mutilation and to save all that could prove useful to his patient. As a gynecologist he kept himself abreast with the progress of the day, and was very successful in the treatment of diseases of women. He was an accomplished obstetrician.

He was the embodiment of sound social and professional ethics, was a favorite with all his medical acquaintances and the most popular doctor I ever knew. He was an elder brother to the younger members of the profession. All who had the talismanic letters M.D. attached to their names, whether merited or not, received the same polite attention when calling on him in his office as did the most distinguished and veteran practitioner. He would extend to the merest tyro in medicine the same urbanity and patiently listen to what they had to say with the same attentive consideration that was extended to the most accomplished members of his profession. His professional modesty was proverbial with all who knew him. His only ambition consisted in being thoroughly prepared to meet any all demands of a local practice of medicine and surgery. If the unselfish love for the honor of the professson as invariably practiced by precept and example in the life of our departed friend could animate the entire guild there would be no necessity for the written code of medical ethics.

J. P. THOMAS, M.D.

BOOK NOTICES.

L'ENSEIGNEMENT ET L'ORGANIZATION DE L'ART DENTAIRE AUX ÉTATS UNIS. Par Le Dr. KUHN. 8vo, paper. 1888.

Many of our readers who attended the Ninth International Congress, will remember with pleasure the rotund and happy Dr. Kuhn who attended the Dental Section and spoke English with fluency. He came to this country under orders from the Minister of Public Instruction of France, to investigate and report upon the existing State of the practice of dentistry in the United States. He faithfully executed the commission, and this elaborate book, well illustrated, is the result. In it he gives the history of each dental college in the United States, gives their

methods of instruction, describes their buildings, and finally gives the laws relating to the practice of dentistry in each State and Territory in the Union. Thus it will be seen that it constitutes a useful compendium for those interested in that branch of Medical Art. In a supplement he briefly describes the status of dental instruction and practice in England and Germany. He laments the fact, that in France the practitioners of dentistry are neither on the same plane with those of other countries, nor is the French system of instruction at all equal to that of the United States. He puts the question in this way: "Let us take two young men equally intelligent, leaving at the age of 18 to pursue the different systems. One studies medicine and works hard for 8 years; the last year he becomes an assistant at the office of a dentist, from which he shortly becomes doctor.

"The other enters as an apprentice and passes all the grades of a school; he commences as apprentice, then a mechanician, then an operator, and when he shall have passed two years or less in a working office he may then establish himself. Which is the better practitioner of the two? For an impartial man of affairs, no doubt is possible.

"The possession of a medical diploma, never constitutes a guarantee of professional superiority." Dr. Kuhn's work, as it deserves to be, has been well received in Paris, and as a book of reference on this subject it will always be of value.

MISCELLANY.

TRAINING OF SOLDIERS IN NURSING DUTIES IN THE EAST INDIAN ARMY.—The following rules proposed by the Surgeon-General, Her Majesty's Forces, for the training of soldiers in nursing duties, have been approved by His Excellency the Commander-in-Chief, and are published for guidance:

1. A certain number of men, who may voluntarily present themselves, and who as orderlies in attendance upon serious cases of illness, have shown an aptitude for this work, shall be trained in nursing duties, so that they may be available for assisting in the care of sick comrades when required, and for duty in time of war in hospitals in the field.

2. The course of study, which is entirely distinct from the training of stretcher bearers, to comprise the subjects contained in Part II of the Manual of the Medical Staff Corps.

3. Each course to consist of twelve lectures, and to extend over a period of three months; the theoretical portion being supplemented by practical instruction in the hospitals. Two courses of lectures to be given in the year, in such British Garrisons as the General Officers Commanding Districts, in consultation with Deputy Surgeons-General may decide, the number of men attending each class being limited to fifteen.

4. The instructor to be an officer of the Medical Staff, nominated by the Deputy Surgeon-General of the Circle, and assisted in this duty by one of the medical subordinates attached to the Station Hospital, and a steady non-commissioned officer to be detailed by the military authorities.

5. At the termination of the course an examination should be held, and certificates of proficiency given to those members of the class who have been regular in their attendance, and whose knowledge of the subject is satisfactory.

6. The appliances, instruments, etc., necessary for carrying out the instruction being available in every Station Hospital, the proposal need entail no expense to the State. It will, however, be necessary that two full sized diagrams, (1) the skeleton showing the ligaments, and (2) the heart, blood-vessels, and muscles, be provided.

Nursing Orderlies.—The Commander-in-Chief has had under consideration the question of providing a trained establishment of ward servants for employment as nursing orderlies in hospitals of native troops and followers.

2. Having in view the importance of raising the efficiency of the class of ward servants, and of providing a reserve for war purposes, the Government of India has sanctioned the enlistment of two ward servants per regiment of native cavalry, as dismounted sowars, and per battalion of native infantry, as sepoys, to be included in the present fixed establishment of corps.

These men are to be enlisted for "general service" in war time, though in peace they will not be liable to transfer. They will be granted all the privileges of the soldier as regards good-conduct pay, furlough and pension, but will never rise above the rank of "Sowar" or "Sepoy."

3. As regards the existing establishment[1] of ward servants, such ward servants as are fully competent may be retained, and if they are willing to accept general service, they should be enlisted under the conditions specified in para. 2. If not enlisted, they will continue to serve on their present conditions, and in those regiments only one soldier ward servant will be entertained.—*Indian Medical Gazette*, November, 1888.

TO EXTERMINATE GROUND SQUIRRELS.—John S. Dillman and William B. Kyle, Moscow, Idaho Ter., have invented a fumigator which is a device for forcing poisonous fumes or gases into holes in the earth to destroy gophers, rabbits, or other burrowing animals, being an exterminator consisting of an an air and smoke pump, and a fire box arranged for easy connection, so as to be readily operated with straw or wood and sulphur.—*Scientific American.*

THE YELLOW FEVER ON THE YANTIC.—The Surgeon-General of the Marine-Hospital Service has received the following letter from the Health Officer of the Port of New York:

HEALTH OFFICER'S DEPARTMENT, State of New York.
QUARANTINE, S. I., January 16, 1889.

The U. S. S. Yantic arrived at Quarantine at 10.30 P.M. of the 10th inst., from Port au Prince, Hayti.

According to the report of Surgeon McCarty, yellow fever developed on board the Yantic the 28th of December, while lying at Port au Prince. Lieut. Charles R. Miles was the first victim. The 29th the second case, in the person of H. L. Kellar, developed. The third case, Cadet M. L. Bristol, occurred on the 30th, and on the 31st ult. Corporal Chas. Wm. Rowe was taken sick, and died on the 7th inst.

January 1st the vessel left Port au Prince. On arrival at quarantine the first three cases that had developed were still sick. The second and third cases in the order of the date of development were doing well. The first case was critically ill and gradually sank until death ensued at 10 P.M. of the 14th inst. The two remaining cases are convalescent.

The Yantic has been undergoing a thorough system of disinfection in every part not occupied by the sick. The case of Lieut. Miles who died on the 14th was so serious

[1] One per regiment.

that I did not think it proper to expose him to the peril of removal to the yellow fever hospital. The course of disinfection will be continued until there is no danger of infection from anything on board of the vessel.

The case of Lieut. Miles was unusually protracted. There were complaints in his case that resisted all efforts of control—hemorrhage from the kidneys constituted the most serious of these.

A careful study of the history of the development of yellow fever on the Boston and Yantic leads to the conclusion that the source of the infection in each instance was in the boats of the natives, known as "bumboats," in which fruit was brought alongside the steamers. My reason for this conclusion will be fully given in my report soon to be made.

Very respectfully,
WM. M. SMITH, Health Officer.

THE DANGER IN MEDICAL ABBREVIATIONS. — We doubt whether many practitioners of medicine who are accustomed to write prescriptions daily, realize the danger their patients run through abbreviated formulas. Some physicians affect an extreme brevity, as if it intimated their superior familiarity with the materia medica. One of the best we ever knew always wrote out fully the names of the drugs in a clear hand and took time to do it. How many sick persons have been poisoned by excusable mistakes on the part of druggists in deciphering prescriptions it would be difficult to say, and the many jokes said to have been practiced on drug clerks whereby a meaningless scrawl was translated into a bottle of some compound, have a basis in fact.

From an exchange the following list is taken, which shows how some common modes of abbreviating may be interpreted to mean severally from two to five different things, some poisonous:

Acid. Hydroc.	May mean Acidum Hydrochloricum, or Acidum Hydrocyanicum.
Aconit.	Aconitine. Aconiti Radix. Aconiti Folia.
Ammon.	Ammonia [alkali]. Ammoniac [gum-resin].
Aq. Chlor.	Aqua Chlori. Aqua Chloroformi.
Aq. Fontis.	May often be read Aqua Fortis.
Calc. Chlor.	Chloride of Calcium. Chlorinated Lime.
Chlor.	Chlorine. Chloroform. Chloral.
Emp. Lyt.	Emp. Lytharg. [lead plaster, old name]. Emp. Lyttae [blistering plaster].
Ext. Col.	Extractum Colchici. Extractum Colicynthidis.
Hyd. Chlor.	Calomel. Corrosive Sublimate. Chloral Hydrate.
Hydr.	Hydrargyrum [mercury]. Hydras [hydrate]. Hydrochloras [hydrochlorate]. Hydrocyanas [hydrocyanate]. Hydriodas [hydriodate].
Mist. Ammon.	Ammonia Mixture. Mixture of Ammoniac [gum-resin].
Potass. Hyd.	Hydrate of Potash [caustic potassa]. Hydriodate of Potash [iodide of potassium].

—*Phrenological Journal.*

THE MARINE HOSPITAL SERVICE.—The bill reorganizing the Marine Hospital Service has become a law. The essential feature of this new law is that appointments to the service are made by the President and confirmed by the Senate. The service is now, therefore, upon the same non-political footing as that of the Army and Navy. Changes in politics can no longer endanger the position or prospects of advancement of its members. In accordance with the law, the President has sent to the Senate a list of names of all the present members of the service for appointment as Surgeons, Assistant Surgeons, and Passed Assistant Surgeons, respectively. Dr. Hamilton has crowned his labors for the promotion of the service in a way which must be most gratifying as it is creditable to him.—*Medical Record.*

SOME ADVANTAGES OF MEMBERSHIP IN MEDICAL SOCIETIES.—There is, perhaps, no other one thing that conduces so much to the advancement of medical science as does the active, working medical society. Now and then we hear it said, "The profession is going wild over medical societies; they are getting to be entirely too numerous." Those who hold this view lose sight of the fact that compulsory attendance upon society meetings is a thing unknown. Every one will admit that it is possible for a physician to devote so much time and attention to society work as to seriously affect his private practice, but a smaller number of patients are lost in this way than by the stay-at-home plan.

The *Maryland Medical Journal* says: "By the thoughtful, live physician, the question, 'does it pay to belong to a medical society?' will always be answered in the affirmative." This, however, is not apparent to many, as the remuneration, in dollars and cents, comes in an indirect way. The *Journal* continues thus:

"The amount of practical information which a physician may gain from the discussions of an active society is beyond all calculation."

Nor does the medical society teach him less about himself. It gives him opportunity to compare himself with his fellows, to silently note the points in which he is deficient. It trains him to greater accuracy in the study of his cases, and greater care in their treatment, especially if, from time to time, he brings the more interesting ones among them to the notice of the society.

Here and there may be found an active, pushing city practitioner who is a member of no society, but this is a rare exception. Our best workers are society men.—*Weekly Medical Review.*

DISAPPEARANCE OF YELLOW FEVER FROM TAMPA.—The Board of Health issued in December last the following proclamation declaring the county free from yellow fever:

TAMPA, FLA., DECEMBER 20, 1888.

At the meeting of the Hillsborough County Board of Health held in this city yesterday the following resolutions were adopted:

WHEREAS, There have been no new cases of yellow fever in Tampa since the 3d instant, and the county and city being entirely free from yellow fever

Resolved, 1. That the Board of Health hereby officially declares the city of Tampa, and the county of Hillsborough, free from the presence of any and all infectious and contagious diseases; and that in our opinion no risk from yellow fever would be incurred by unacclimated persons visiting and residing in Tampa, or any place in the county.

Resolved, 2. That as there have only been ten deaths from yellow fever in the city of Tampa, during the summer and fall of 1888, it is very evident that Tampa has not suffered from any very extensive epidemic. Furthermore, in all houses where the disease has prevailed, so far as known to the Board of Health, all necessary measures to eradicate the poison have been taken; so that the Board of Health feels justified in declaring that no apprehension need be entertained on that account by people wishing to come to Tampa, and Hillsborough County.

JOHN P. WALL, M.D., President.

Attest:—D. POST, Secretary.

—*Weekly Abstract of Sanitary Reports, Jan. 4, 1889.*

A CHRISTIAN SCIENCE FAD.—

"Think health and health will find you
As certain as the day,
And pain will lag behind you
And lose you on the way."

Why not pursue this same line of reasoning to the bitter end, something after this fashion:

Think wealth and you will get it—
A million, more or less;
Think silk and in the closet
You'll find a gros grain dress.

Think land when you are drowning,
Beyond all human reach,
And by this happy theory
You'll be washed up on the beach.

Think bread when you are hungry
And a feast will there be spread;
Think sleep when you are weary
And you'll find yourself in bed.

—*Harper's Magazine.*

PAMPHLETS RECEIVED.

Tilley, R., M.D., Chicago, Ill. *A Case of Atrophy of the Supercilia and Cilia, Associated with Atrophy of All the Finger-nails, of Congenital Origin.* Reprint from THE JOURNAL, January 12, 1889.

Knapp, Philip Coombs, A.M., M.D., Boston, Mass. *Some Post-Hemiplegic Disturbances of Motion in Children.* Reprint from the Boston Medical and Surgical Journal, November 22, 1888.

Knapp, Philip Coombs, M.D. *Nervous Affections following Injury.* Reprint from Boston Med. and Surg. Journal. 1888.

Clevenger, S. V., M.D. *Spinal Concussion.* Reprint from THE JOURNAL. 1889.

Sternberg, Geo. M., M.D., U. S. Army. *Recent Researches Relating to the Etiology of Yellow Fever.* Reprint from Trans. Assoc. Amer. Physicians. 1888.

Eastman, Joseph, M.D. *Intraligamentous Tubal Pregnancy.* Reprint from Am. Jour. of Obstet. and Dis. of Women and Children. 1888.

Mateer, Horace N., M.D., Ph.D. *Science in Medicine.* Graduating Thesis. Reprint from the Post-Graduate and Wooster Quarterly. Wooster, O. 1888.

Middlekamp, H. H., M.D. *Are Immediate Amputations Justifiable?* Reprint from Progress.

Stewart, Hon. W. H., U. S. Senator from Nevada. *Money Answereth All Things.* Reprint from Congressional Record. 1889.

Cutler, Ephraim, M.D., LL.D. *The Contras and Pros of the Cutler Stem Pessary.* Reprint from Albany Medical Annals. 1888.

Chicago College of Pharmacy, Twenty-seventh Announcement. 1889.

Jacobson, Nathan, M.D. *A Contribution to the Study of Tumors.* Reprint from THE JOURNAL. 1889.

LETTERS RECEIVED.

John A. Larrabee, M.D., Louisville, Ky.; Electron Mfg. Co., New York; S. S. White Dental Mfg. Co., Philadelphia; Codman & Shurtleff, Boston, Mass.; J. H. Bates, New York; W. M. Barritt, M.D., Onarga, Ill.; Henry O. Marcy, M.D., Boston, Mass.; F. E. Yoakum, Greenville, Tex.; A. B. Younkman, Brenen, Ind.; A. G. Myers, New York; L. Duncan Bulkley, M.D., New York; Herbert E. Smith, M.D., New Haven, Conn.; C. W. Richardson, M.D., Washington, D. C.; Alex. Boggs, M.D., Paris; Owen Mead, M.D., Newmarket, England; H. Judd, M.D., Galesburg, Ill.; S. P. Deahofe, Potsdam, O.; Mary Hayden, Freeport, Ill.; M. Paul Gibier, N. Y. City; P. O. Hooper, M.D., Little Rock, Ark.; S. C. McCormick, M.D., Duluth, Minn.; J. O. Stanton, M.D., Washington, D. C.; Ephraim Cutter, M.D., N. Y. City; H. A. Kimball, M.D., Chicago; B. Chapman, M.D., Copley, Ohio; Ira B. Read, M.D., New York City; Samuel L. Nelson, M.D., Boston, Mass.. John S. Coleman, M.D., Augusta, Ga.; Mr. G. E. Law, Brooklyn, N. Y.; Robert G. Ellegood, M.D., Concord, Del.; John Wilkinson, M.D., Oshawa, Ont.; O. J. Vincent, M.D., Allegheny City, Pa.; W. C. Brinkerhoff, M.D., Chicago, Ill.; Lloyd Brothers, Cincinnati, O.; A. G. Case, M.D., Denver, Col.; Mr. W. W. Brinton, Sharpsburg, Pa.; P. Blakiston, Son & Co., Philadelphia, Pa.; J. P. Fouch, M.D., Osage Mission, Kan.; C. L. Kinnaman, M.D., Cleveland, Ohio; Cranston & Co., Norwich, Conn.; H. Salzer, M.D., Baltimore, Md.; Chas. D. Pearson, M.D., Indianapolis, Ind.; Wm. B. DeWees, M.D., Salina, Kan.; G. D. Parker, M.D., McKinney, Texas; A. S. von Mansfelde, M.D., Ashland, Neb.; *The Cleveland Medical Gazette*, Cleveland, Ohio; A. J. Scott, A.M., M.D., Londonville, Ohio; Miss C. B. Leonard, New York, N. Y.; D. R. Armitage, M.D., Muncie, Ind.; W. W. Potter, M.D., Buffalo, N. Y.; Wm. Forster, M.D., South Oil City, Pa.; Frank Kenyon, M.D., Scipio, N. Y.; J. C. Hearne, M.D., Hannibal, Mo.; F. R. Reynolds, M.D., Menominee, Wis.; Ward Brothers, Jacksonville, Ill.; Fred Humbert, M.D., Alton, Ill.; H. R. Middelkamp, Warrenton, Mo.; J. M. Toner, M.D., Washington, D. C.; R. C. M. Page, M.D., N. Y.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from January 12, 1889, to January 18, 1889.

By direction of the President, and in accordance with Section 1246, Revised Statutes, an Army Retiring Board is appointed to meet in this city, at 11 o'clock A.M., Thursday, the 17th day of January, 1889, for the examination of such officers as may be ordered before it. Detail for the Board: Col. Jedediah H. Baxter, Chief Medical Purveyor, and Major Charles R. Greenleaf, Surgeon U. S. Army. Par. 2, S. O. 12, A. G. O., Washington, January 15, 1889.

Lieut.-Col. Charles H. Alden, Surgeon, and Capt. Edgar A. Mearns, Asst. Surgeon U. S. Army, detailed for duty on Army Retiring Board to meet at St. Paul, Minn., at the call of the President thereof. Par. 7, S. O. 10, A. G. O. Washington, January 12, 1889.

Capt. Richard W. Johnson, Asst. Surgeon U. S. Army, is granted leave of absence for fourteen days. Par. 1, S. O. 8, A. G. O., Washington, January 10, 1889.

By direction of the Secretary of War, Capt. James E. Pilcher, Asst. Surgeon, will repair from Ft. Wood, New York Harbor, to Philadelphia, Pa., at such time as his services can be spared, for the purpose of giving instruction to the Hospital Corps of the First Brigade National Guard of Pennsylvania. Par. 6, S. O. 8, A. G. O., Washington, January 10, 1889.

By direction of the Secretary of War, Capt. Benjamin Munday, Asst. Surgeon, is relieved from duty at Ft. Sisseton, Dak., and will report in person to the commanding officer, Ft. Sully, Dak., for duty at that post, Par. 2, S. O. 11, A. G. O., Washington, January 14, 1889.

First Lieut. Henry S. T. Harris, Asst. Surgeon U. S. Army, will, upon the arrival of Acting Asst. Surgeon Boyer, proceed from Camp Pena, Colorado, to the post of San Antonio, Texas, and report to the commanding officer for temporary duty. Par. 4, S. O. 1, Hdqrs. Dept. of Texas, San Antonio, Tex., January 2, 1889.

Official List of Changes in the Medical Corps of the U. S. Navy for the Week Ending January 19, 1889.

P. A. Surgeon A. H. Dickson, detached from the "Pensacola" and to the "Atlanta."

Asst. Surgeon F. W. Olcott, detached from the "Atlanta" and to the "Vermont."